

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff	)	
	)	
vs	)	19-CR-250
	)	
MARTIN EVERS,	)	
	)	
Defendant	)	
_____	)	

TRANSCRIPT OF PROCEEDINGS  
*Daubert Hearing In Re: Dr. Stephen Thomas*  
BEFORE THE HONORABLE ROBERT D. MARIANI  
THURSDAY, MARCH 11, 2021; 10:30 A.M.  
SCRANTON, PENNSYLVANIA

FOR THE GOVERNMENT:  
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Proceedings recorded by machine shorthand, transcript produced  
by computer-aided transcription.

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## I N D E X

Witness:	Direct	Cross	Redirect	Recross
Dr. Stephen Thomas	7	74	117	--

## E X H I B I T

## I N D E X

For the Government:	Identified	Admitted
Exhibit No. 1	7	8
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1 THE COURT: Good morning, everyone.

00:00 2 MS. OLSHEFSKI: Good morning, Your Honor.

00:00 3 MR. CASEY: Good morning.

00:00 4 MR. BRIER: Good morning, Your Honor.

00:00 5 THE COURT: This is the matter of United States v. Martin

00:00 6 Evers. In accordance with our telephone conference of Thursday,

00:00 7 March 4, we are here to receive evidence with respect to two of

00:00 8 the motions that have been filed on behalf of the Defendant.

00:00 9 The first is the Motion to Exclude the opinion and

00:00 10 testimony of Dr. Stephen Thomas; and the second is a Motion to

00:00 11 Suppress the search and seizure of 104 Bennett Avenue, Suite

00:00 12 3C, Milford PA on August 6th, 2019.

00:00 13 Ms. Olshefski, if you will recall, in our telephone

00:01 14 conference of March 4, we discussed the commencement of the

00:01 15 proceeding by your presentation of an offer of proof with

00:01 16 respect to Dr. Thomas, specifically, indicating the basis on

00:01 17 which you seek him to be qualified, and if qualified, the

00:01 18 opinion that he would render.

00:01 19 Are you prepared to submit that now?

00:01 20 MS. OLSHEFSKI: I am, Your Honor.

00:01 21 THE COURT: Please.

00:01 22 MS. OLSHEFSKI: Your Honor, the United States is offering

00:01 23 the expert testimony of Dr. Stephen Thomas to testify about the

00:01 24 events surrounding the death of Kristina Dame. Dr. Thomas has

00:01 25 authored two expert reports in this case, wherein, he has

00:01 1 written about Kristina Dame's medical history and events  
00:01 2 leading up to her death and will be offered to testify about  
00:02 3 what he has included in both of those expert reports.

00:02 4 He's being offered to testify about whether, in his medical  
00:02 5 opinion, the prescriptions written by the Defendant, as alleged  
00:02 6 in the indictment, were written in the usual course of  
00:02 7 professional practice and for legitimate medical purposes.

00:02 8 He will be offered to testify about whether, in his medical  
00:02 9 opinion, the prescriptions issued to Kristina Dame by the  
00:02 10 Defendant and used by Kristina were the but-for cause of death  
00:02 11 in this case.

00:02 12 Dr. Stephen Thomas, who is in the courtroom and will be  
00:02 13 called to testify, in addition to his many professional  
00:02 14 accomplishments, is a Diplomate of The American Board of  
00:02 15 Anesthesiology with a subspecialty certification in Pain  
00:02 16 Medicine. He's also a Certified Independent Medical Examiner.

00:02 17 Dr. Thomas has been qualified as an expert in this very  
00:02 18 area, in multiple Federal and State Courts, including multiple  
00:02 19 times within the Third Circuit.

00:02 20 Dr. Thomas was qualified as an expert in this very area in  
00:03 21 the Middle District of Pennsylvania by the late Honorable A.  
00:03 22 Richard Caputo in the matter of United States v. Fuhai Li.  
00:03 23 The Defense there sought to exclude Dr. Thomas' testimony for  
00:03 24 similar reasons that are offered here by this Defendant.

00:03 25 They allege that, first, Dr. Thomas is not qualified. They

1 allege that Dr. Thomas' conclusions are not supported by  
2 sufficient facts or data. They allege that his conclusions are  
3 not the result or the use of reliable principles and methods.  
4 And that Dr. Thomas did not reliably apply principles and  
5 methods to this case.

6 In Li, Judge Caputo rejected that same attempt and allowed  
7 Dr. Thomas to testify. Judge Caputo found him qualified as a  
8 medical expert and admitted his expert testimony at trial. In  
9 that trial, Dr. Thomas testified that certain prescriptions  
10 were not issued in the usual course of professional practice  
11 and not for legitimate medical purposes. And in one case in  
12 that trial, he opined as to the but-for cause of death.

13 When Li pressed that issue on appeal to the Third Circuit,  
14 the Third Circuit affirmed Judge Caputo's opinion regarding  
15 Dr. Thomas' expert testimony.

16 In another matter that is currently pending before this  
17 district, before the Honorable Matthew W. Brann, captioned at  
18 United States v. Raymond Kraynak, the Defense sought there to  
19 preclude the testimony of Dr. Thomas, for reasons similar to  
20 what this Defendant is doing and argues here. The Government  
21 previously supplemented its response to the Motion to Preclude  
22 with the memorandum opinion authored by Judge Brann denying  
23 that motion, which was issued on November 9, 2020 approving the  
24 expert testimony of Dr. Thomas, as to the validity of the  
25 prescriptions at issue, not issued in the usual course of

00:05 1 professional practice and without legitimate medical purpose  
00:05 2 and the but-for cause of death in that case.

00:05 3 Your Honor, I understand that this authority is not  
00:05 4 binding -- either, Judge Caputo or Judge Brann's decisions are  
00:05 5 not binding on Your Honor, but we argue that those decisions  
00:05 6 are persuasive. And we also rely on the additional cases cited  
00:05 7 in our response brief in support of the admission of  
00:05 8 Dr. Thomas' testimony.

00:05 9 Your Honor, with that, I'm ready to proceed.

00:05 10 THE COURT: Who will be questioning here?

00:05 11 MR. BRIER: I will, Your Honor. Frank Brier on behalf of  
00:05 12 Dr. Evers.

00:05 13 THE COURT: Mr. Brier, do you wish to make any statement  
00:05 14 before we begin?

00:05 15 MR. BRIER: No, Your Honor. I understand that's argument,  
00:05 16 it's not evidence. I'm prepared to proceed.

00:05 17 THE COURT: Very well. You can call your first witness.

00:06 18 MS. OLSHEFSKI: Thank you, Your Honor. The United States  
00:06 19 calls Dr. Stephen Thomas.

00:06 20 S T E P H E N T H O M A S, M. D. IS CALLED, AND HAVING  
00:06 21 BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

00:06 22 THE CLERK: Please state your name and spell it for the  
00:06 23 record.

00:06 24 THE WITNESS: My name is Stephen, S-T-E-P-H-E-N, Michael  
00:06 25 M-I-C-H-A-E-L, Thomas, T-H-O-M-A-S, M.D.

00:06 1 THE CLERK: Thank you. Please be seated.

00:07 2 MS. OLSHEFSKI: Your Honor, the witness has a binder in  
00:07 3 front of him, which includes exhibits that the United States  
00:07 4 may refer Dr. Thomas to during the testimony.

00:07 5 The same binder has been provided to the Court, as well as  
00:07 6 Defense counsel.

00:07 7 THE COURT: Thank you.

00:07 8 MS. OLSHEFSKI: Your Honor, may I stay at counsel table to  
00:07 9 question?

00:07 10 THE COURT: Yes.

00:07 11 DIRECT EXAMINATION

00:07 12 BY MS. OLSHEFSKI:

00:07 13 Q. Good morning, Dr. Thomas.

00:07 14 A. Good morning.

00:07 15 Q. Please introduce yourself to Your Honor.

00:07 16 A. I am Stephen Thomas, I'm a pain medicine physician.

00:07 17 THE COURT: Very pleased to meet you.

00:07 18 BY MS. OLSHEFSKI:

00:07 19 Q. Dr. Thomas, there is a binder in front of you; correct?

00:07 20 A. Yes.

00:07 21 Q. Can you please turn to Government's Exhibit 1 in that  
00:07 22 binder. And can you please let me know if you can identify  
00:07 23 Government's Exhibit 1?

00:07 24 A. Yes, it is my curriculum vitae.

00:07 25 Q. Prior to coming in to court today, did you provide that

00:07 1 curriculum vitae to the United States?

00:07 2 A. I did.

00:07 3 Q. Is it a current and up-to-date curriculum vitae?

00:07 4 A. Yes, it was last updated in October of 2020.

00:08 5 MS. OLSHEFSKI: Your Honor, I move for admission of  
00:08 6 Government's Exhibit No. 1.

00:08 7 THE COURT: Any objection, Mr. Brier?

00:08 8 MR. BRIER: No objection, Your Honor.

00:08 9 THE COURT: Government's 1 is admitted.

00:08 10 (At this time Government's Exhibit No. 1 was admitted into  
00:08 11 evidence.)

00:08 12 BY MS. OLSHEFSKI:

00:08 13 Q. So Dr. Thomas, I'd like to go over some of what is  
00:08 14 included in your curriculum vitae, okay. First of all, what  
00:08 15 type of physician are you?

00:08 16 A. I'm an anesthesiologist by training, with subspecialty  
00:08 17 training in pain medicine. I am a pain medicine physician.

00:08 18 Q. Are you licensed to practice medicine the Commonwealth of  
00:08 19 Pennsylvania?

00:08 20 A. I have been so since 1992.

00:08 21 Q. Since 1992?

00:08 22 A. Yes.

00:08 23 Q. I want to start first talking about your education, okay,  
00:08 24 your undergraduate education. Where did you go to college?

00:08 25 A. Initially, I went to Slippery Rock State College, and I

00:08 1 took my degree from the Case Western Reserve University in  
00:08 2 Cleveland, Ohio, majoring in Biology with minor concentrations  
00:08 3 in Chemistry, Philosophy and Psychology.

00:08 4 Q. And after graduating from college, what did you do next?

00:09 5 A. I went to medical school at Stanford University School of  
00:09 6 Medicine, where I obtained my M.D. in 1984. After medical  
00:09 7 school, I did an internship at The Presbyterian University of  
00:09 8 Pennsylvania Medical Center, followed by a residency in  
00:09 9 anesthesiology at Johns Hopkins Hospital in Baltimore,  
00:09 10 Maryland.

00:09 11 After completing my residency in anesthesiology, I did a  
00:09 12 Fellowship in pain medicine and regional anesthesia, also, at  
00:09 13 Johns Hopkins Hospital, where I was the Chief Resident in the  
00:09 14 Department of Anesthesiology and Critical Care Medicine.

00:09 15 Q. Let me just stop you there for a moment. You performed an  
00:09 16 internship at the Presbyterian University of Pennsylvania  
00:09 17 Medical Center; correct?

00:09 18 A. Yes.

00:09 19 Q. How long was that internship?

00:09 20 A. It was one year, a rotating internship, including all  
00:09 21 medical disciplines the old fashioned way.

00:09 22 Q. The residency in anesthesiology at Johns Hopkins Hospital  
00:10 23 in Baltimore, how long was that, and what did you do as a  
00:10 24 resident in anesthesiology?

00:10 25 A. It was an additional two years of specialty training in

00:10 1 Anesthesiology and Critical Care Medicine. It included  
00:10 2 rotations in the division of anesthetics to geriatric  
00:10 3 individuals, pediatrics, obstetrics and gynecology and general  
00:10 4 and regional anesthetics for operative procedures.

00:10 5 Q. When we talk about anesthetics and anesthesiology, what is  
00:10 6 that?

00:10 7 A. Anesthesiology is the subspecialty of medicine,  
00:10 8 specifically, concerned with the provision of appropriate  
00:10 9 surgical conditions, rendering patients insensible to pain,  
00:10 10 during the course of operations, and their care in the critical  
00:10 11 care setting post-operatively, during the periods of recovery  
00:10 12 from anesthesia, as well as the care of trauma patients and  
00:11 13 patients in labor and delivery, as well as pediatric patients.

00:11 14 It's a generalist specialty, specifically, concerning the  
00:11 15 pharmacology, physiology and anatomy of the provision of  
00:11 16 anesthetics.

00:11 17 Q. That was two years?

00:11 18 A. That was a two-year course?

00:11 19 Q. You indicated that you were Chief Resident of The  
00:11 20 Department of Anesthesiology and Critical Care Medicine. Did  
00:11 21 you become Chief Resident during that residency?

00:11 22 A. During my fellowship year, I was appointed Chief Resident.  
00:11 23 Of the 75 residents in the program, four are selected for  
00:11 24 various reasons of excellence in the department to become Chief  
00:11 25 Resident. It is a middle management leadership position within

00:12 1 the department during the course of the year.

00:12 2 Q. Now, at some point subsequent to that training, did you  
00:12 3 find yourself in the military?

00:12 4 A. Actually, I was planning -- since they paid for Stanford,  
00:12 5 I went to -- I was on reserve duty in the Air Force, during the  
00:12 6 course of my medical training, and then I owed four years of  
00:12 7 active duty in the United States Air Force.

00:12 8 I was assigned to the Wright Patterson United States Air  
00:12 9 Force Medical Center in Dayton, Ohio, where I was the Staff  
00:12 10 Anesthesiologist. While there, I developed the first pain  
00:12 11 medicine center for the central region of the Air Force, and  
00:12 12 rose to the rank of Major and was the Assistant Chief of  
00:12 13 Anesthesia Services while at Wright Patt. I was there for four  
00:12 14 years.

00:13 15 Q. After four years of serving in the military, what did you  
00:13 16 do then?

00:13 17 A. I obtained an Honorable Discharge first, then I returned  
00:13 18 to my hometown of Pittsburgh, Pennsylvania, where I was Staff  
00:13 19 Anesthesiologist and Pain Medicine Physician for Pittsburgh  
00:13 20 Anesthesia Associates, a large anesthesia group covering,  
00:13 21 approximately, seven hospitals in the Pittsburgh area.

00:13 22 Our main hospital was Mercy Hospital of Pittsburgh, where  
00:13 23 I initially worked half in the operating room and half in the  
00:13 24 pain medicine center training residents and providing  
00:13 25 inpatient, outpatient and subspecialty pain medicine services

00:13 1 across multiple hospitals.

00:13 2 Q. You were one of a group of physicians performing these  
00:13 3 services?

00:13 4 A. Yes, there were 40 anesthesiologists in the group and four  
00:14 5 pain medicine physicians, so during that time, we provided both  
00:14 6 inpatient consultation, as well as ran an outpatient clinic for  
00:14 7 referrals to the pain medicine service.

00:14 8 We also provided services at the Healthsouth Harnmarville  
00:14 9 Rehabilitation Hospital, where we ran a multi-disciplinary  
00:14 10 chronic pain and function restoration program, concentrating on  
00:14 11 minimizing drug therapy, improving patient function, dealing  
00:14 12 with their psychological issues and issues of addiction,  
00:14 13 regarding their interaction with pain medicines, as well as  
00:14 14 attempting to return injured workers to work.

00:14 15 Q. How long did you do that, Dr. Thomas?

00:14 16 A. I was with Pittsburgh Anesthesia Associates for eight  
00:15 17 years, from 1992 until 2000.

00:15 18 Q. So when you were involved in that large group, you  
00:15 19 indicated that some of the services, anesthesia services, were  
00:15 20 performed at a hospital, in addition to a clinic, inpatient and  
00:15 21 outpatient.

00:15 22 How did you divide your time or what was the quantity  
00:15 23 of -- how was your time divided?

00:15 24 A. When I started, I did 50 percent O.R. anesthesia and 50  
00:15 25 percent pain medicine, because they offered me a job with both,

00:15 1 and, at the time, that's what I wanted to do. Between 1992 and  
00:15 2 1999, I gradually performed more and more pain medicine  
00:15 3 services because of the demand and less and less operative  
00:15 4 time.

00:15 5 And in about 1999, I realized that my partners didn't know  
00:15 6 the dose of intrathecal baclofen for the treatment of spinal  
00:16 7 spasticity, and I shouldn't have to try to remember everything  
00:16 8 about anesthesia and pain medicine, so I began to devote 100  
00:16 9 percent of my time to my pain medicine practice.

00:16 10 THE REPORTER: Excuse me. Can you repeat that medical term?

00:16 11 THE WITNESS: I'm sorry. I said my partners didn't know the  
00:16 12 dose of intrathecal baclofen for the treatment of spinal  
00:16 13 spasticity, therefore, I couldn't keep all the information  
00:16 14 about anesthesia in my head, as well.

00:16 15 BY MS. OLSHEFSKI:

00:16 16 Q. So since 1999, you have practiced exclusively in pain  
00:16 17 medicine; correct?

00:16 18 A. Yes.

00:16 19 Q. Did you form a company, at that point, or did you form a  
00:16 20 name for your practice?

00:16 21 A. Well, once I decided to leave the anesthesia group to  
00:16 22 concentrate on my practice, both in pain medicine and in  
00:16 23 medical legal work, I formed the company Pain and Disability  
00:17 24 Management Consultants, which was, initially, a small physician  
00:17 25 group of three.

00:17 1 Over the course of the next three years, my partners  
00:17 2 decided that they needed to have jobs, as opposed to running a  
00:17 3 practice, and it became my solo private practice from 2002  
00:17 4 through 2014.

00:17 5 Q. Just for that period of time, 2002 to 2014, were you  
00:17 6 treating patients hands on?

00:17 7 A. Oh, yes, during that period, I was seeing a regular  
00:17 8 outpatient clinic on a daily basis, from 2002 through 2014, as  
00:17 9 well as doing some inpatient consultation at the hospitals  
00:17 10 where I was on staff, functioning as a member of the hospital  
00:17 11 staff and coverage staff for the pain medicine services, where  
00:18 12 I -- at the hospitals where I worked, as well as admitting some  
00:18 13 patients for those instances when they required inpatient  
00:18 14 evaluation and treatment.

00:18 15 Q. Now, I think you used the term, interventional pain  
00:18 16 management.

00:18 17 A. Yes.

00:18 18 Q. Would you please explain to the Court what that means?

00:18 19 A. The interventional portion of my practice was the  
00:18 20 performance of injection therapy, nerve blocks and other  
00:18 21 injections, as well as the implantation of, either, spinal  
00:18 22 pumps, infusion devices that deliver medications directly to  
00:18 23 the spinal cord and spinal cord stimulators. The implantation  
00:18 24 of devices that send electrical nerve impulses to the spinal  
00:19 25 cord and nerve roots, in order to minimize pain.

00:19 1 The interventional portion of our practice was,  
00:19 2 approximately, half of our practice, the other portion of our  
00:19 3 practice was the provision and management of rehabilitative  
00:19 4 services and medication management for the treatment of chronic  
00:19 5 pain.

00:19 6 Q. Correct me if I'm wrong, but this was -- these were  
00:19 7 multiple ways of attacking a patient's pain?

00:19 8 A. Yes, the subspecialty of pain medicine is the garnering of  
00:19 9 all of the possible mechanisms by which -- and therapeutics by  
00:19 10 which we can diminish a patient's pain and improve their  
00:19 11 function and improve their lives, and, therefore, it includes  
00:19 12 interventions such as, injections, stimulators, pumps,  
00:19 13 occasionally, a referral for operation and management of their  
00:20 14 pain in the post-operative period.

00:20 15 It includes the monitoring and instruction of physical  
00:20 16 therapists for function restoration, and it includes the  
00:20 17 psychological support and/or referral of the patients for  
00:20 18 helping them with the suffering that is the human condition of  
00:20 19 chronic pain.

00:20 20 But at the same time, we manage the medications that we  
00:20 21 use in the treatment of pain, trying to get the right medicine  
00:20 22 to the right people in the right way.

00:20 23 Q. Dr. Thomas, you're Board certified?

00:20 24 A. I'm certified by The American Board of Anesthesiology. I  
00:20 25 have a subspecialty certification in Pain Medicine. I've been

00:20 1 re-certified, now, three times over the course -- since my  
00:21 2 initial certification. I'm a former Fellow of Interventional  
00:21 3 Pain from the World Institute of Pain. I am a Certified  
00:21 4 Independent Medical Examiner from the American Board of  
00:21 5 Independent Medical Examiners, regarding the evaluation of  
00:21 6 patients for independent assessment.

00:21 7 I have a Certificate of Competence in Controlled  
00:21 8 Substances Management and Practice Management from the American  
00:21 9 Board of Interventional Pain Physicians.

00:21 10 Q. Now, before I move on, you indicated that you have a  
00:21 11 Certificate of Competence in the Management of --

00:21 12 A. Controlled substances.

00:21 13 Q. -- Controlled Substances. What does that mean?

00:21 14 A. Like all certifications, it's a pencil and paper test  
00:21 15 after training, regarding the appropriate management of  
00:22 16 controlled substances, in the treatment of chronic pain,  
00:22 17 including the controlled substances at issue today, opioids, as  
00:22 18 well as the management of anti-convulsants, sedatives,  
00:22 19 hypnotics, drugs that make you sleepy, and other controlled  
00:22 20 substances that may interact with -- in the chronic pain  
00:22 21 setting.

00:22 22 Q. We often hear the term, pain medicine, alongside of, pain  
00:22 23 management. Can you please distinguish those for us?

00:22 24 A. I call my specialty pain medicine because it is about the  
00:22 25 diagnosis, primarily, and evaluation and long-term treatment of

00:22 1 patients with acute chronic and cancer pain. That is what I  
00:22 2 think about, what I do. Pain management is the term that's  
00:23 3 applied to the things we do, in order to interfere with pain  
00:23 4 signals. It is a narrow part of what we do.

00:23 5 I don't call what I do pain management because it  
00:23 6 concentrates too much on the doing and not enough on the  
00:23 7 thinking about the overall problems of patients with pain.

00:23 8 Q. Dr. Thomas, do you still see patients?

00:23 9 A. I currently see independent medical examinations, I do not  
00:23 10 have an active clinical practice. So I continue to see one to  
00:23 11 four independent medical examinees for evaluation of their  
00:23 12 ongoing treatment, primarily, in the Worker's Compensation  
00:23 13 setting, at this point.

00:24 14 Q. I also see on your curriculum vitae that you act as an  
00:24 15 expert and consultant for The Pennsylvania Medical Society  
00:24 16 Physician's Health Program. Is that correct?

00:24 17 A. Yes.

00:24 18 Q. What is that and what do you do as a consultant?

00:24 19 A. The Physician's Health Program is a branch of the  
00:24 20 Pennsylvania Medical Society, particularly concerned with the  
00:24 21 treatment of impaired physicians, with the most common  
00:24 22 impairment being addiction.

00:24 23 I have consulted with them in the evaluation of a number  
00:24 24 of physicians and dentists with chronic pain who have become  
00:24 25 impaired, secondary to their abuse and addiction to opioid

00:24 1 analgesics and other related drugs. So I've offered them  
00:25 2 opinions about the fitness of that physician for return to duty  
00:25 3 and treatment plans associated with the balance of managing  
00:25 4 their chronic pain and their impairment and how to deal with  
00:25 5 it.

00:25 6 Also, because of my long-term interest in the problem of  
00:25 7 addiction, arising from the use of pain medicines, I am a  
00:25 8 member of The American Society of Addiction Medicine and have  
00:25 9 lectured on the balance between pain treatment and addiction.

00:25 10 Q. I also see that you have acted or you continue to act as a  
00:25 11 consultant for The Department of State Bureau of Professional  
00:25 12 and Occupational Affairs. What is that?

00:25 13 A. That has been in the evaluation of the prescribing of  
00:25 14 physicians in the Commonwealth of Pennsylvania, but also the  
00:26 15 State of Delaware. The administrative evaluation of physician  
00:26 16 prescribing of controlled substances and whether or not they  
00:26 17 were prescribed within the standard of care and within the  
00:26 18 appropriate professional bounds for both the Commonwealth of  
00:26 19 Pennsylvania, The Department of Medicine -- I'm sorry -- The  
00:26 20 Bureau of Medicine, as well as Osteopathy.

00:26 21 Q. What is that, Doctor?

00:26 22 A. Doctors are either M.D.'s and are managed by the Board of  
00:26 23 Medicine or D.O.'s, osteopaths, and they're managed by The  
00:26 24 Board of Osteopathy. The standards for prescribing, however,  
00:26 25 are the same.

00:26 1 Q. On your curriculum vitae, Doctor, there is an indication  
00:26 2 that you consult with the Attorney General's Office Medicaid  
00:27 3 Strike Task Force and Drug Task Force for the Pennsylvania AG's  
00:27 4 Office.

00:27 5 A. Yes.

00:27 6 Q. What do you do for them?

00:27 7 A. It is similar to the work that I do for the Department of  
00:27 8 Justice. Most of the cases I have reviewed for them have been  
00:27 9 about these particular issues, has the prescribing been for a  
00:27 10 medically legitimate purpose, in the usual course of  
00:27 11 professional practice, when a patient -- I'm sorry -- when a  
00:27 12 physician has been charged or being investigated for violations  
00:27 13 of the Pennsylvania Controlled Substances Act, which applies at  
00:27 14 a State level, as the Federal Controlled Substances Act applies  
00:27 15 at a Federal level.

00:27 16 Q. So I want to go back one step. When you consult for the  
00:27 17 Department of State, regarding professional misconduct alleged  
00:28 18 against physicians, are you, basically, reviewing what  
00:28 19 physicians have done, in providing an opinion?

00:28 20 A. Yes, I'm reviewing the medical record. Occasionally, there  
00:28 21 are additional -- there's additional information from  
00:28 22 investigation with which I'm provided that I will also take  
00:28 23 into account in the evaluation of the physician's behavior,  
00:28 24 but, primarily, it's about prescribing drugs that are used in  
00:28 25 the treatment of pain, primarily, controlled substances.

00:28 1       However, the provision of non-controlled substances, under  
00:28 2 certain circumstances, have been parts of the -- in the  
00:28 3 evaluation, particularly, with respect to Medicare or Medicaid  
00:28 4 fraud.

00:28 5 Q.   Now, when you engage in these types of investigations, as  
00:29 6 you've just described, what do you perceive your duty to be?

00:29 7 A.   My duty is to pull back the veil that stands behind the  
00:29 8 multi-syllabic words that we use in medicine, and to describe  
00:29 9 to lay people, precisely, what is happening with the medicine,  
00:29 10 in terms of the standards from inside of medical practice.

00:29 11       That is, to teach people about what medicine is, how  
00:29 12 medicine should be normatively, how we should be practicing,  
00:29 13 and to describe deviations, if any, from that north star.

00:29 14 Q.   I note there are numerous lectures identified on your  
00:29 15 curriculum vitae. Have any of those lectures, specifically,  
00:29 16 focused on the nature and prescribing of controlled substances?

00:30 17 A.   Most of them have, probably, 15 or 20. The issue of  
00:30 18 controlled substances prescribing has persistently been a  
00:30 19 problem throughout most of the 21st century, but, particularly,  
00:30 20 beginning in the ops, about 2005 or so, the issue of controlled  
00:30 21 substances prescribing and the overuse of medications became  
00:30 22 progressively a problem.

00:30 23       So talking about how we use controlled substances and how  
00:30 24 do we -- how should we not use controlled substances in various  
00:30 25 patient populations, the addicted individual, the injured

00:30 1 worker, across the board, has been something that I've talked  
00:30 2 about on a number of occasions. I've offered several trainings  
00:31 3 to law enforcement to help them identify appropriate controlled  
00:31 4 substances prescribing and to elucidate where the problems may  
00:31 5 lie and what are the issues that could portend a problematic  
00:31 6 prescriber.

00:31 7 Q. And you identified law enforcement as being part of the  
00:31 8 audience that you address. Who else would comprise the  
00:31 9 audiences to whom you lecture?

00:31 10 A. I've lectured to community organizations of only lay  
00:31 11 people and those who are interested in the treatment of  
00:31 12 addiction, I've lectured to medical organizations, giving grand  
00:31 13 rounds at hospitals. So the expansion is broad from lay  
00:31 14 individuals to medical organizations, as well as law  
00:32 15 enforcement and anyone who is interested in the problem that  
00:32 16 has been generated, identified by the CDC in 2011 as the opioid  
00:32 17 epidemic.

00:32 18 Q. So you're familiar with that term, an opioid epidemic?

00:32 19 A. Yes.

00:32 20 Q. Have you, in fact, lecture on, specifically, the opioid  
00:32 21 epidemic?

00:32 22 A. Yes, I have.

00:32 23 Q. Have you, specifically, made presentations or lectured on  
00:32 24 chronic pain?

00:32 25 A. Yes, the issue of chronic pain is the reason that we found

00:32 1 it necessary to liberalize our use of controlled substances  
00:32 2 and the balance between the treatment of the pain and the  
00:32 3 treatment of the problems that occur with the increasing use of  
00:32 4 any medical therapy has been a specific interest of mine.

00:33 5 Q. Have you conveyed what you've learned in your knowledge to  
00:33 6 your colleagues who do the same thing that you do, in terms of  
00:33 7 lectures or presentations or teachings?

00:33 8 A. Yes.

00:33 9 Q. Now I also note that, on your curriculum vitae, you are a  
00:33 10 certified -- you're certified as a DATA Waived Physician. Is  
00:33 11 that correct?

00:33 12 A. Yes, I am.

00:33 13 Q. What does that mean?

00:33 14 A. DATA or the Drug Addiction Treatment Act of 2000 allowed  
00:33 15 physicians in the outpatient setting to treat addiction, which  
00:33 16 had not had been allowed before. The treatment of addiction,  
00:33 17 under the DATA waiver is, specifically, limited to Schedule 3  
00:33 18 substances approved by the FDA for the outpatient treatment of  
00:33 19 addiction, specifically, buprenorphine in its various forms.

00:34 20 The DATA Waived physician undergoes, at least, eight hours  
00:34 21 of training and is allowed to prescribe buprenorphine for the  
00:34 22 chronic treatment of the chronic disease of addiction in an  
00:34 23 outpatient fashion.

00:34 24 Q. You mentioned buprenorphine. Would that involve the use of  
00:34 25 Methadone for treatment of addiction?

00:34 1 A. No, it would not. Methadone is only allowed in the  
00:34 2 outpatient treatment programs that are specifically licensed by  
00:34 3 the Federal Government for that purpose. The prescription of  
00:34 4 Methadone is allowed to physicians for the treatment of pain,  
00:34 5 but not for the treatment of addiction, which would place it  
00:34 6 outside of the usual course of professional practice, because  
00:34 7 it would be beyond the licensing that we hold as providers.

00:35 8 Q. So is there something unique about Methadone, compared to  
00:35 9 the other opioids that you have learned that require special  
00:35 10 training or special caution, when prescribing it?

00:35 11 A. Beginning in 2007, the FDA placed a black box warning on  
00:35 12 Methadone and warned that physicians should be especially  
00:35 13 careful because there was a spike in the number of overdoses  
00:35 14 associated with the use of Methadone, particularly, the 40  
00:35 15 milligram diskette, which was removed from the market for  
00:35 16 general distribution because of the nature of Methadone.

00:35 17 Methadone differs from all of the other opioids in our  
00:35 18 rumentarium, our bag of tricks, in that, it is different in its  
00:35 19 pharmacology from the other drugs. Pharmacology is divided into  
00:36 20 pharmacokinetics and pharmacodynamics. The way in which the  
00:36 21 drug moves through the body, pharmacokinetics, and  
00:36 22 pharmacodynamics, the way the drug acts in the body  
00:36 23 dynamically.

00:36 24 Methadone is the only long-acting opioid that is long  
00:36 25 acting because of the way the body handles it. Because of that,

00:36 1 Methadone being a very potent drug, is more potent the more  
00:36 2 that you take it, and that's different from every other drug of  
00:36 3 the opioid-type, which is potent, at the time that you take it,  
00:36 4 and stays at the same potency the more that you take it. It's  
00:36 5 because Methadone builds up in the body, because it's not  
00:36 6 eliminated, and, therefore, after a period of time, it is more  
00:36 7 potent and more toxic than it would be when you first begin to  
00:36 8 take the drug.

00:36 9 Q. Now, prior to coming in to court, you talked about a black  
00:37 10 box label on Methadone. Did you provide the Government with a  
00:37 11 Methadone insert that is included in Methadone packages?

00:37 12 A. Yes, it's the prescribing information for Methadone. This  
00:37 13 one is, particularly, for the manufacturer of the brand name  
00:37 14 Dolophine, but Methadone is Methadone, and it contains all of  
00:37 15 the prescribing information that any practitioner prescribing  
00:37 16 Methadone would be required to know.

00:37 17 Q. So I want to, specifically, direct your attention to the  
00:37 18 Government's Exhibit No. 10 that's in the binder in front of  
00:37 19 you and ask you if you can identify what Exhibit No. 10 is?

00:37 20 A. Exhibit No. 10 is the Roxane Laboratory prescribing  
00:37 21 information for Dolophine, Methadone hydrochloride tablets.

00:37 22 Q. So is this -- when someone is prescribed Methadone and  
00:38 23 they walk away with a Methadone package, is this the insert  
00:38 24 that we all get that is voluminous?

00:38 25 A. Not exactly. The part at the back is the patient

00:38 1 information. This is the prescribing information that's in the  
00:38 2 Physician's Desk Reference, the part that the doctor is  
00:38 3 supposed to read.

00:38 4 Q. So directing your attention to the first couple paragraphs  
00:38 5 of Government Exhibit No. 10, you're familiar with what that  
00:38 6 says; correct?

00:38 7 A. Yes.

00:38 8 Q. Could you read first paragraph for us, please?

00:38 9 A. "Deaths. Cardiac and respiratory have been reported during  
00:38 10 initiation and conversion of pain patients to Methadone  
00:38 11 treatment from treatment with other opioid agonists. It is  
00:38 12 critical to understand the pharmacokinetics of Methadone, when  
00:38 13 converting patients from other opioids. See dosage  
00:38 14 administration.

00:38 15 "Particular vigilance is necessary during treatment  
00:38 16 initiation during conversion from one opioid to another and  
00:39 17 during dose titration."

00:39 18 Q. What is dose titration?

00:39 19 A. That is, as you get to the right dose for the patient,  
00:39 20 generally, the axiom is to start low and go slow. I  
00:39 21 always -- dose titration, I compare it to salting of food. You  
00:39 22 don't dump in a whole box of Morton's at the beginning, you  
00:39 23 start at some and you add to taste.

00:39 24 The titration of medications is very similar. You start  
00:39 25 with some, an amount that you know will not be too much, and

00:39 1 you gradually increase it, in order to get the best possible  
00:39 2 effect for the patient, while minimizing side effects and  
00:39 3 potential harm.

00:39 4 Q. Read the second paragraph, please.

00:39 5 A. "Respiratory depression is the chief hazard associated  
00:39 6 with Methadone hydrochloride administration. Methadone's peak  
00:39 7 respiratory depression effects typically occur later and  
00:39 8 persists longer than its peak analgesic effects, particularly,  
00:40 9 in the early dosing period.

00:40 10 "These characteristics can contribute to cases of  
00:40 11 iatrogenic overdose, particularly, during treatment initiation  
00:40 12 and dose titration."

00:40 13 Q. So Dr. Thomas, is that what you previously testified to,  
00:40 14 about the, what I'll call the half life of Methadone in the  
00:40 15 body?

00:40 16 A. Yes, that is, as Methadone is handled in the body, it  
00:40 17 builds up, in terms of its dose, because the average half life  
00:40 18 is about 24 hours, then, it takes about five days for most  
00:40 19 people, but the half life may be longer, up to 56 hours in some  
00:40 20 patients, so it will take even longer for them to get to the  
00:40 21 maximal amount that will in their bodies at what's called  
00:40 22 steady state.

00:40 23 Q. Could you read the next paragraph, please?

00:40 24 A. "In addition, cases of QT interval prolongation and  
00:40 25 serious arrhythmias, torsades de pointes, have been observed in

00:41 1 treatment with Methadone. Most cases involve patients being  
00:41 2 treated for pain with large multiple daily doses of Methadone,  
00:41 3 although, cases have been reported in patients receiving  
00:41 4 Methadone commonly used for maintenance treatment of opioid  
00:41 5 addiction."

00:41 6 Q. And the next one, please.

00:41 7 A. "Methadone treatment for analgesic therapy in patients  
00:41 8 with acute or chronic pain should only be initiated if the  
00:41 9 potential analgesic or palliative care benefit of treatment  
00:41 10 with Methadone is considered and outweighs the risk."

00:41 11 Q. Now, you indicated that this Government's Exhibit No. 7 is  
00:41 12 what the doctor should have and know before prescribing  
00:41 13 Methadone?

00:41 14 A. It is the most basic information regarding the drug.

00:41 15 MS. OLSHEFSKI: Your Honor, I'd move for admission of  
00:41 16 Government's Exhibit No. 7.

00:41 17 THE COURT: 7?

00:41 18 MS. OLSHEFSKI: No. 10, I'm sorry.

00:41 19 THE COURT: Mr. Brier?

00:41 20 MR. BRIER: No objection, Your Honor.

00:42 21 THE COURT: Government 10 is admitted.

00:42 22 (At this time Government's Exhibit No. 10 was admitted  
00:42 23 into evidence.)

00:42 24 BY MS. OLSHEFSKI:

00:42 25 Q. If I were to use the term, Morphine Milligram Equivalents,

00:42 1 what is that?

00:42 2 A. Morphine Milligram Equivalents refers to the fact that all  
00:42 3 opioids act by the same mechanism. That mechanism is the  
00:42 4 stimulation or agonism of new receptors, morphine receptors in  
00:42 5 the brain and spinal cord. Thus, all opioids can be compared to  
00:42 6 morphine, in order for us to compare drugs that have different  
00:42 7 names and slightly different characteristics, in terms of their  
00:42 8 potency.

00:42 9 Q. So we have been talking about Methadone. Is there  
00:42 10 something unique about Methadone, even when it comes to  
00:42 11 equating it to morphine?

00:42 12 A. Yes.

00:42 13 Q. Tell us what that is.

00:42 14 A. Methadone acutely, that is, the first time that you give  
00:43 15 it in the short term, is roughly equivalent to Methadone during  
00:43 16 the first day, so 10 milligrams of Methadone is roughly  
00:43 17 equivalent to 10 milligrams of morphine.

00:43 18 Once one continues to dose Methadone, then, Methadone,  
00:43 19 once in the chronic phase, is four times as potent as morphine  
00:43 20 during its low dose treatment. So from 1 to 20 milligrams per  
00:43 21 day, Methadone is approximately 4 times as potent as morphine,  
00:43 22 and so we use a factor of 4 to convert Methadone milligrams to  
00:43 23 milligrams of morphine equivalents.

00:43 24 So 10 milligrams of Methadone per day is roughly  
00:43 25 equivalent to 40 milligrams of morphine per day. As we increase

00:43 1 the dose of Methadone, 20 to 60 is approximately eight times as  
00:44 2 potent -- I'm sorry 20 to 40 is eight times as potent -- 40 to  
00:44 3 60 is 10 times as potent, and over 60 milligrams of Methadone  
00:44 4 per day, the factor of conversion is 12.

00:44 5 So 100 milligrams of Methadone per day is equivalent to  
00:44 6 1200 milligrams of morphine equivalents.

00:44 7 Q. A day?

00:44 8 A. Per day, yes.

00:44 9 Q. I'm going to come back to talking about that in a moment,  
00:44 10 but I want to get back to your experience.

00:44 11 Can you give us a sense of the types of patients that you  
00:44 12 have predominantly treated over the 30 years of being a doctor?

00:44 13 A. Yes. Well, my experience with pain patients has been  
00:44 14 fairly vast. I've worked with thousands of patients with  
00:44 15 chronic pain, due to headache, neck pain, back pain, limb  
00:45 16 injuries, neuropathic or nerve pain, spinal cord injuries,  
00:45 17 multiple work injuries. The most injured person I ever saw was  
00:45 18 electrocuted as a line man and one of his arms had come off, so  
00:45 19 he had multiple injuries throughout his joints, bones, nerves  
00:45 20 and spinal cord.

00:45 21 I have -- the most common -- with all physicians, common  
00:45 22 things are common, so the most common pains in a pain medicine  
00:45 23 center are back pain and headache, and so I've treated a lot of  
00:45 24 back pain and headache. But the pains of degenerative disease  
00:45 25 have also been part of my practice.

00:45 1 For a time, I treated a convent, so nuns live forever, and  
00:45 2 they live cleanly, so their bodies simply break down, so I've  
00:46 3 seen a lot of degenerative disease associated with joint, bone,  
00:46 4 ligament and nerve problems.

00:46 5 I've treated neuropathic pain from diabetes postherpetic  
00:46 6 neuralgia and the like. The pain of headache associated with  
00:46 7 high pressure hydrocephalus, headache associated with migraine,  
00:46 8 headache associated with trauma and concussion. So all of the  
00:46 9 mechanisms by which pain can occur. Cancer pain, as well, have  
00:46 10 been part of the patient population that I've treated over the  
00:46 11 years.

00:46 12 Q. That would be over, approximately, 30 years?

00:46 13 A. Yes.

00:46 14 Q. And we're talking thousands and thousands?

00:46 15 A. Yes.

00:46 16 Q. Can you put a number on the patients that you have  
00:46 17 actually provided care for?

00:46 18 A. Tens of thousands.

00:46 19 Q. I want to talk to you, now, about when you're asked to  
00:47 20 provide expert opinions, such as in this case, okay?

00:47 21 A. Yes.

00:47 22 Q. When you're asked to provide expert services, do you rely  
00:47 23 on your training that you have just described?

00:47 24 A. Yes.

00:47 25 Q. And do you rely on the experience as a medical doctor,

00:47 1 pain medicine doctor that you've just described?

00:47 2 A. Yes.

00:47 3 Q. Now, have you previously testified in courts of law as an  
00:47 4 expert, in one or more of the various aspects of your medical  
00:47 5 career?

00:47 6 A. I have.

00:47 7 Q. Have you previously testified as an expert in criminal  
00:47 8 cases?

00:47 9 A. I have.

00:47 10 Q. Would that be both in State Court and Federal Court?

00:47 11 A. That is correct, both in Pennsylvania, Delaware and Ohio.

00:47 12 Q. Have you previously testified as an expert in civil cases?

00:47 13 A. Yes.

00:47 14 Q. Would that be in similar -- in Pennsylvania or any other  
00:48 15 jurisdiction?

00:48 16 A. Yes.

00:48 17 Q. Now, in the cases -- in civil cases, have you testified  
00:48 18 for both the Plaintiff and Defendant?

00:48 19 A. Yes.

00:48 20 Q. In criminal cases, have you testified for both the  
00:48 21 Prosecution and the Defendant?

00:48 22 A. I've only testified for the Prosecution. I've been  
00:48 23 retained by the Defense on two occasions and rendered opinions  
00:48 24 but was not called to testify.

00:48 25 Q. And I see on your curriculum vitae that you act as a

00:48 1 consultant or have acted as a consultant for Cuyahoga  
00:48 2 County -- Federal -- I'm sorry, the Public Defender's Office in  
00:48 3 Cuyahoga County?

00:48 4 A. Yes, I was retained as an expert for a physician who was  
00:48 5 charged with prescribing not for a medically legitimate purpose  
00:48 6 in the usual course of professional practice, and I rendered an  
00:48 7 opinion but was not called to testify.

00:49 8 Q. That was for the Defendant?

00:49 9 A. That was for the Defense, yes.

00:49 10 Q. Cuyahoga County is located where?

00:49 11 A. In Cleveland, Ohio.

00:49 12 Q. The nature of the testimony that you've provided in your  
00:49 13 career, has it involved pain medicine -- your expert opinions  
00:49 14 -- have those opinions involved pain medicine?

00:49 15 A. Pain medicine or anesthesia.

00:49 16 Q. Has it involved the cause of death, when pain medicine is  
00:49 17 involved?

00:49 18 A. Yes, on several occasions.

00:49 19 Q. Has your expert opinions, have they involved addiction  
00:49 20 from time to time?

00:49 21 A. Yes, they have.

00:49 22 Q. And has there ever been a time in a Court of Law when you  
00:49 23 have been deemed unqualified to testify in these areas?

00:49 24 A. Never.

00:49 25 Q. One more question on that issue. Have you previously been

00:49 1 qualified as an expert to testify in a case such as this, where  
00:49 2 you're being asked to opine about the propriety of lawfulness  
00:50 3 -- not lawfulness -- but whether or not prescriptions are  
00:50 4 issued in the usual course of professional practice for  
00:50 5 legitimate medical purposes?

00:50 6 A. Yes, repeatedly.

00:50 7 Q. And also involving a but-for cause of death standard in  
00:50 8 those cases, have you testified to that?

00:50 9 A. Yes, I have.

00:50 10 Q. Okay, I want to talk to you about the approach that you  
00:50 11 took in this case. Specifically, can you advise the Court what  
00:50 12 you were specifically asked to do in this case?

00:50 13 A. I was provided with multiple records, and I was asked to  
00:50 14 evaluate whether or not the prescriptions that were written to  
00:50 15 Kristina Dame were written for a medically legitimate purpose  
00:50 16 in the usual course of professional practice. That standard is  
00:50 17 the standard by which the prescriptions must be evaluated.

00:50 18 As you noted, in civil cases, the standard is different  
00:51 19 because it's about the standard of care. From a medical point  
00:51 20 of view, would a physician -- would a responsible physician act  
00:51 21 in a certain manner.

00:51 22 Particularly, in the Commonwealth of Pennsylvania, the  
00:51 23 standard for whether or not a prescription is provided for a  
00:51 24 medically legitimate purpose in the usual course of  
00:51 25 professional practice is defined. Medicine is a regulated

00:51 1 industry and physicians are responsible for knowing those  
00:51 2 regulations and definitions. In Pennsylvania, a prescription  
00:51 3 must be written in good faith, within the scope of the  
00:51 4 doctor-patient relationship and in accordance with the accepted  
00:51 5 treatment principles of any responsible segment of the medical  
00:51 6 community.

00:51 7 And that standard is the standard by which I would  
00:51 8 evaluate a prescription written by a physician in the  
00:51 9 Commonwealth.

00:51 10 Q. In fact, is that a standard that you have been held to  
00:52 11 throughout your entire career?

00:52 12 A. Absolutely.

00:52 13 Q. So you were asked to do that. Did you, in fact, do that?

00:52 14 A. Yes.

00:52 15 Q. So I'm going to talk to you for a moment but the records  
00:52 16 that you reviewed, regarding Kristina Dame. Do you recall off  
00:52 17 the top of your head or can you give us a sense of your  
00:52 18 recollection of what you reviewed?

00:52 19 A. I immediately turned to my -- I've reviewed a lot of  
00:52 20 records about Ms. Dame. I reviewed a separate set for my first  
00:52 21 report and then reviewed a larger set that was -- that included  
00:52 22 the first set for my second report.

00:52 23 Q. Okay, so let's start with the actual -- Kristina's actual  
00:52 24 medical file from the Defendant Martin Evers. Did you review  
00:52 25 that medical file?

00:52 1 A. I did.

00:52 2 Q. And did you review the autopsy report related to  
00:53 3 Kristina's death?

00:53 4 A. I did.

00:53 5 Q. Did you review the toxicology report associated with  
00:53 6 Kristina Dame's death?

00:53 7 A. Yes.

00:53 8 Q. Did you review medical records that were provided by the  
00:53 9 coroner in certain office notes, at the time of Kristina's  
00:53 10 death, which was September 11, 2014?

00:53 11 A. I did.

00:53 12 Q. Did you look at and review prescriptions that were  
00:53 13 prescribed to Kristina Dame by the Defendant?

00:53 14 A. Yes.

00:53 15 Q. Did you review an interview that was conducted by the DEA  
00:53 16 Agent of Kristina's mother Margaret Dame?

00:53 17 A. Yes.

00:53 18 Q. Did you review an interview of the Defendant, at the time  
00:53 19 of a search warrant and/or arrest?

00:53 20 A. I reviewed the transcript, initially, and later I watched  
00:54 21 a video of the interview.

00:54 22 Q. Now, we're going to talk a little bit more in a moment  
00:54 23 about the PDMP report. In this case, did you review the

00:54 24 Prescription Drug Monitoring Report for Kristina Dame?

00:54 25 A. I did.

00:54 1 Q. Do you have a recollection of reviewing hospital records  
00:54 2 from Wayne Memorial Hospital?

00:54 3 A. I reviewed those later.

00:54 4 Q. But you did review them?

00:54 5 A. Yes.

00:54 6 Q. How about hospital records from First Valley Hospital for  
00:54 7 Kristina Dame?

00:54 8 A. First Health.

00:54 9 Q. How about records from the Horsham Clinic? Do you recall  
00:54 10 reviewing those?

00:54 11 A. Yes, I do.

00:54 12 Q. Did you review any hospital records from Bon Secours?

00:54 13 A. Yes, I did.

00:54 14 Q. How about Geisinger Hospital records for Kristina Dame?  
00:54 15 Did you review those?

00:54 16 A. I did.

00:54 17 Q. Did you review the Pennsylvania State Police reports  
00:54 18 regarding Kristina's death?

00:54 19 A. I did.

00:54 20 Q. Did you, also, have an opportunity to review photographs  
00:54 21 of the scene of Kristina's death?

00:55 22 A. I did.

00:55 23 Q. Can you give us a sense of the volume of pages of records  
00:55 24 that you have reviewed, prior to reaching opinions and/or  
00:55 25 conclusions?

00:55 1 A. It would be, at least, 7 or 8,000 pages of records.

00:55 2 Q. So let's talk about the approach that you took or what I  
00:55 3 will refer to as your methodology.

00:55 4 A. Yes.

00:55 5 Q. Do you have a methodology that you follow, when you're  
00:55 6 asked to do what you were asked to do in this case?

00:55 7 A. I do.

00:55 8 Q. Can you please explain that approach or methodology to the  
00:55 9 Court?

00:55 10 A. Well, the most important thing is to not miss anything, so  
00:55 11 I read, virtually, all of the record, except where -- because  
00:55 12 of the nature of medical records, they tend to be very  
00:55 13 repetitive, so a lot of it is page-turning, but paying  
00:56 14 particular attention to those instances where the physicians  
00:56 15 made direct entries of, either, observations of the patient or  
00:56 16 recommendations, relative to the patient's care.

00:56 17 Putting that into a chronological pattern, in order to  
00:56 18 determine which of the things that were recommended or observed  
00:56 19 by physicians occurred in what order, because that order  
00:56 20 becomes important, and to the extent possible, attempting to  
00:56 21 determine what parts of her care that was provided in the  
00:56 22 necessary fragmented nature of the current U.S. medical system  
00:56 23 was communicated from doctor to doctor, in order to know what  
00:56 24 the information base upon which the Defendant was making  
00:57 25 decisions and whether or not that was adequate for the

00:57 1 decisions made.

00:57 2       Additionally, determining over the course of time how the  
00:57 3 patient was responding to treatment and were there observations  
00:57 4 made both by the Defendant and by other physicians that would  
00:57 5 allow a clear reckoning of her overall condition.

00:57 6       Included in there because of the nature of the care was  
00:57 7 whether or not information was being provided to the Defendant  
00:57 8 from other sources that would allow him to have a fulsome view  
00:57 9 of the patient's condition.

00:57 10       Part of that evaluation is based upon my training,  
00:58 11 experience and knowledge of the drugs involved and the  
00:58 12 diagnoses, both psychological, as well as -- which  
00:58 13 psychological diagnoses are medical -- but psychological and  
00:58 14 physical, in terms of determining what that patient would look  
00:58 15 like and what things would be expected to be occurring with  
00:58 16 her, in the usual course of professional practice.

00:58 17       Then, taking all of that information, in terms of history,  
00:58 18 physical examination, diagnostic data, consultation and the  
00:58 19 temporal arrangement of those, comparing those, first, to the  
00:58 20 standard treatment protocols, which are determined by the  
00:58 21 various guidelines and regulations that physicians follow or  
00:59 22 physicians should follow, in the provision of medical care, and  
00:59 23 trying to make a determination about, A, Is the treatment first  
00:59 24 within the standard guideline package, that is, if a physician  
00:59 25 were to follow all of the guidelines, that would be putative

00:59 1 evidence that the prescribing was for a medically legitimate  
00:59 2 purpose in the usual course of professional practice, because  
00:59 3 it would be virtually impossible to be within the safe harbor  
00:59 4 of the guidelines and not be prescribing for a medically  
00:59 5 legitimate purpose.

00:59 6       Secondarily, if the guidelines are not followed then to  
00:59 7 what extent does that occur? Because there are simple mistakes  
00:59 8 which are expected. There are omissions or commissions which  
01:00 9 are unexpected but simply bad medicine. There are occurrences  
01:00 10 that occur that are negligent, but even that would not be not  
01:00 11 for a medically legitimate purpose in the usual course of  
01:00 12 professional practice.

01:00 13       In order to make the determination that the prescribing is  
01:00 14 not for a medically legitimate purpose in the usual course of  
01:00 15 professional practice, the behavior must be so far from the  
01:00 16 center line of what we should do, as to be unrecognizable as  
01:00 17 the practice of medicine.

01:00 18       And it is then and only then that I would make that  
01:00 19 determination.

01:00 20 Q.   So I want to talk to you about -- well, did you do all  
01:00 21 that in this case?

01:00 22 A.   Yes.

01:00 23 Q.   So let's talk about the -- some of the authorities that  
01:00 24 you relied on, as you're working your way through those  
01:01 25 thousands and thousands of pages, okay. Are there different

01:01 1 categories of authorities that you rely on, as support for your  
01:01 2 knowledge and opinions in reaching conclusions?

01:01 3 A. Yes.

01:01 4 Q. Okay, and what are the different kinds of categories?

01:01 5 A. I think, first, there are the -- the plain statement of  
01:01 6 the law that governs the practice of medicine. It is not a  
01:01 7 legal opinion to understand that a prescription must be written  
01:01 8 for a medically legitimate purpose in the usual course of  
01:01 9 professional practice as being the standard by which I would be  
01:01 10 evaluating any physician's behavior in this context.

01:01 11 Further, it's not a legal opinion, but the standard that  
01:01 12 the Pennsylvania Controlled Substances Act describes what that  
01:01 13 is for patients in the Commonwealth of Pennsylvania and using  
01:01 14 that to evaluate the behavior.

01:02 15 Then, I would turn to the administrative sources,  
01:02 16 particularly, the PA code 15.92, which -- Title 21 15.92, which  
01:02 17 states the prescribing, dispensing and administering of  
01:02 18 prescriptions and what is expected of a physician,  
01:02 19 administratively, in the course of performing that activity.

01:02 20 Then, I think I would turn, then, to more medical sources  
01:02 21 but that still tend to be administrative. For example, the  
01:02 22 Federation of State Medical Boards Model Policy For Use of  
01:02 23 Opioids in the Treatment of Chronic Pain. That document has  
01:02 24 been updated multiple times. It was first published in 1998,  
01:02 25 updated in 2004 and then in 2013 and using those sequential

1 updates, as part of the temporal overlay in time during which  
2 the prescribing occurred.

3 Because, virtually, all of the records that I -- the  
4 records here with Ms. Dame, the 2013 model policy was utilized,  
5 using the descriptions in the model policy of what the  
6 physician should do, and, in fact, what are the areas in which  
7 The Federation of State Medical Boards of which Pennsylvania is  
8 a signatory had described problematic prescribing by  
9 physicians, in order to alert physicians as to what we should  
10 be doing, at that point, that was not as clearly outlined in  
11 the 2004 model policy.

12 Then, the CDC guidelines, which I did not apply to Ms.  
13 Dame but to other patients that I have reviewed, because the  
14 CDC guidelines were not published until March of 2016, and,  
15 therefore, a physician would not be responsible for the CDC  
16 guidelines in the evaluation of their prescribing behavior,  
17 even though, some of the information that is in the CDC  
18 guidelines was being put into the milieu of our prescribing  
19 over the period between 2013 and 2016.

20 Additionally, I used the medical literature, the medical  
21 literature that, initially, allowed and encouraged physicians  
22 to liberalize their prescribing. The consensus statement on The  
23 Use of Opioids in the Treatment of Chronic Pain published by  
24 The American Pain Society and The American Academy of Pain  
25 Medicine in 1996 represented a C-change in the way in which we

01:05 1 prescribe opioid analgesics, but then the warnings from the FDA  
01:05 2 that came, particularly, in 2004 and 2007, with the declaration  
01:05 3 of opioid epidemic in 2011, is part of the back-drop for  
01:05 4 utilizing the medical information.

01:05 5 And, particularly, the guidelines published by The  
01:05 6 American Pain Society and an article by Dr. Roger Chou in 2009,  
01:05 7 also, represents the underlying medical basis of the evaluation  
01:05 8 of the center line of opioid prescribing, that is, the  
01:05 9 normative practice of how we should prescribe opioids.

01:06 10 I think it's important to say that the guidelines,  
01:06 11 however, are mostly descriptive and encourage a certain  
01:06 12 normative behavior. Very rarely do the guidelines say, Don't do  
01:06 13 "X". They imply not to do "X" because they say do "Y", and if  
01:06 14 you do "Y", you won't do "X". But very rarely is anything in  
01:06 15 medical practice laid out to say, A doctor should never do "X",  
01:06 16 "Y" or "Z".

01:06 17 So the guidelines are not directly related to the  
01:06 18 determination of whether or not prescribing is for a medically  
01:06 19 legitimate purpose in the usual course of professional  
01:06 20 practice, that is, actually, a judgment based upon how far from  
01:06 21 the guidelines and the normative practice the prescribing is.

01:07 22 Q. I'm just going to go through some of those authorities  
01:07 23 that you identified in a lit bit more detail. But before I do  
01:07 24 that, everything that you've just described, has it been your  
01:07 25 practice, in rendering expert opinions, to rely on all of

01:07 1 those?

01:07 2 A. It has been my practice in rendering expert opinions and  
01:07 3 my practice in writing thousands of prescriptions to rely upon  
01:07 4 those.

01:07 5 Q. You mentioned medical associations and medical boards. In  
01:07 6 Pennsylvania, particularly, is there -- I think you mentioned a  
01:07 7 code, The Pennsylvania Code in Pennsylvania that provides  
01:07 8 guidelines for physicians?

01:07 9 A. Yes.

01:07 10 Q. So is that true?

01:07 11 A. Yes, it is.

01:07 12 Q. So I want to direct your attention to, specifically,  
01:07 13 Government's Exhibit No. 8 in the binder in front of you.

01:08 14 A. Yes, Title 49, 1692.

01:08 15 Q. Are you familiar with that part of the Pennsylvania Code  
01:08 16 identified as prescribing, administering and dispensing  
01:08 17 controlled substances?

01:08 18 A. Yes.

01:08 19 Q. Again, this is -- these are guidelines in this part of the  
01:08 20 Pennsylvania Code that you routinely rely on; correct?

01:08 21 A. Yes.

01:08 22 Q. And, in particular, what is this Pennsylvania Code Section  
01:08 23 16.92, which is Title 49, what does it advise physicians that  
01:08 24 they should do?

01:08 25 A. When I read the 1692, I basically hear the code saying,

01:08 1 Make sure you practice medicine, when you're giving out  
01:09 2 controlled substances, because harm can occur. It says we  
01:09 3 should initially evaluate the patient with history and  
01:09 4 physical. It says that we should re-evaluate the patient at  
01:09 5 intervals to make sure that the medication we're giving them is  
01:09 6 causing -- is doing good and not doing harm.

01:09 7 It says we should counsel patients about the pros and cons  
01:09 8 of the medication. And this is particularly true with  
01:09 9 controlled substances and opioids, because these are, at the  
01:09 10 very least, they are habituating and, at worst, they are  
01:09 11 addictive. And that we should keep medical records that say  
01:09 12 what is -- what have we been trying to do with the medication  
01:09 13 and what do we see as the effect of the medication.

01:09 14 And have we done those things, in terms of instructing the  
01:09 15 patient and giving them directions about how to use the drug  
01:09 16 that will make it most effective. And that we should comply  
01:10 17 with the current standards in prescribing the drugs.

01:10 18 Q. And, particularly, particular to this case, did you, in  
01:10 19 fact, rely on that section of the Pennsylvania Code titled,  
01:10 20 Prescribing, Administering and Dispensing Controlled  
01:10 21 Substances, Section 1692, in reaching the opinions and  
01:10 22 conclusions that you reached in this case?

01:10 23 A. Yes, it is background information.

01:10 24 Q. Are you familiar with the Title 21 CFR Section 1306.04,  
01:10 25 and that is Government's Exhibit No. 5?

01:10 1 A. Yes, I am.

01:10 2 Q. What is that?

01:10 3 A. That is the purpose of issuing a prescription, it is the  
01:10 4 description that the prescription must be issued for a  
01:10 5 medically legitimate purpose in the usual course of  
01:10 6 professional practice.

01:10 7 Q. So this is a Code of Federal Regulations that is informing  
01:11 8 a practitioner about what the requirements are for a  
01:11 9 prescription to be valid. Would that be accurate?

01:11 10 A. That is correct.

01:11 11 Q. Can you just, please, read the first section, which is  
01:11 12 Subsection A of Title 21 -- I'm sorry -- 21 CFR Section  
01:11 13 1306.04?

01:11 14 A. "A. A prescription for controlled substance to be  
01:11 15 effective must be issued for a legitimate medical purpose by an  
01:11 16 individual practitioner acting in the usual course of his  
01:11 17 professional practice. The responsibility for the proper  
01:11 18 prescribing and dispensing of controlled substances is upon the  
01:11 19 prescribing practitioner, but a corresponding responsibility  
01:11 20 rests with the pharmacist who fills the prescription.

01:11 21 "An order purporting to be a prescription issued not in  
01:11 22 the usual course of professional treatment or in legitimate and  
01:11 23 authorized research is not a prescription within the meaning  
01:11 24 and intent of the section. A person knowingly fulfilling a  
01:12 25 purported prescription, as well as the person issuing it, shall

1 be subject to the penalties provided for violations of the  
2 provisions of law relating to controlled substances."

3 Q. Now, I see the words, corresponding responsibility, when  
4 talking about pharmacists. Can you explain that to us, please?

5 A. In the practice of medicine, the issuing of a prescription  
6 to a patient occurs in a particular setting, and that setting  
7 is a triad, which involves the prescribing physician, the  
8 issuing pharmacist and the patient who is the end user.

9 While the physician is responsible for the decision-making  
10 in determining that a prescription should be issued, the  
11 pharmacist has a responsibility to use his knowledge, training  
12 and, indeed, observations of the patient, in order to alert the  
13 physician, from time to time, of things that the physician may  
14 or may not know.

15 And the patient bears a responsibility, although, not at  
16 the same level of professionalism as the physician and the  
17 pharmacist, to alert the physician and the pharmacist to things  
18 that the physician or pharmacist may or may not know.

19 It is in that triad, which is not -- in which all parties  
20 are a part, but which the professional responsibilities lie  
21 with the physician and the pharmacist, in terms of the level of  
22 knowledge training, education and understanding of the  
23 underlying pharmacology that is required, in order to  
24 legitimize the prescription of a controlled substance.

25 Q. Did you rely on this particular section of the CFR

01:14 1 identified in Government's Exhibit No. 5 in reaching the  
01:14 2 opinions and conclusions that you reached in this case?

01:14 3 A. This is the gold standard, this is the standard by which  
01:14 4 the opinion must be based or it would not be valid.

01:14 5 Q. I want to direct your attention, now, to Government's  
01:14 6 Exhibit No. 6. Are you familiar with what Government's Exhibit  
01:14 7 No. 6 is?

01:14 8 A. Yes.

01:14 9 Q. And is it correct that you have in front of you Title 21  
01:14 10 United States Code Section 829 titled, Prescriptions?

01:14 11 A. Yes.

01:14 12 Q. If you go to the second page of Government No. 6, you see  
01:15 13 Subsection E2, Subsection 2 on the second page, where it says,  
01:15 14 As used in this subsection?

01:15 15 A. Yes.

01:15 16 Q. Okay. Is this another area of the title -- is this a  
01:15 17 definitional area of Section 829 of Title 21, which, again,  
01:15 18 defines a valid prescription?

01:15 19 A. Yes, it does. It alerts the physician as to what the  
01:15 20 requisite parameters for the issuance of a valid prescription  
01:15 21 is.

01:15 22 Q. Under Title 21 Section 829, how is a valid prescription  
01:15 23 defined?

01:15 24 A. Again, it's repeated that it's issued for a legitimate  
01:15 25 medical purpose in the usual course of professional practice,

01:15 1 and that the practitioner has conducted an in-person -- at  
01:15 2 least, one in-person examination of the patient or they're a  
01:16 3 covering practitioner, which would be a person who is, instead  
01:16 4 of the physician, covering for their practice.

01:16 5 Q. So would you agree with me that this is a definitional  
01:16 6 section of that title?

01:16 7 A. It is.

01:16 8 Q. Did you rely, also, on this section in Government's  
01:16 9 Exhibit No. 6 in reaching the opinions and conclusions that you  
01:16 10 reached in this case?

01:16 11 A. Yes.

01:16 12 Q. I want to direct your attention to one more part of  
01:16 13 Pennsylvania direction, which is found at Government's Exhibit  
01:16 14 4. And in Government's Exhibit 4, are you familiar with Chapter  
01:16 15 25 of the Controlled Substance Drugs, Devices and Cosmetics Act  
01:16 16 the Commonwealth of Pennsylvania?

01:16 17 A. Yes.

01:16 18 Q. And does this particular act also define what a valid  
01:17 19 prescription is?

01:17 20 A. Yes.

01:17 21 Q. So once -- I'd ask that you turn to the next page of  
01:17 22 Government's Exhibit 4 Section 25.52, where it says, Purpose.  
01:17 23 Do you see that?

01:17 24 A. Yes.

01:17 25 Q. And could you please read the subsection A?

01:17 1 A. "A. A prescription for controlled substance must be issued  
01:17 2 for a legitimate medical purpose by a licensed practitioner in  
01:17 3 the usual course of professional practice. The responsibility  
01:17 4 for proper prescribing of controlled substances is upon the  
01:17 5 practitioner, but a corresponding responsibility rests with the  
01:17 6 pharmacist who dispenses the medication and interprets the  
01:17 7 directions of the prescriber to the patient."

01:17 8 Q. So would you agree with me this is a definitional section  
01:17 9 of the purpose of a prescription under Pennsylvania -- under  
01:17 10 the Pennsylvania drug laws?

01:17 11 A. Yes.

01:17 12 Q. We previously went over how the CFR defines a valid  
01:18 13 prescription; correct?

01:18 14 A. That is correct.

01:18 15 Q. Under Federal law.

01:18 16 A. Yes.

01:18 17 Q. And did you rely on Chapter 25 and, particularly, Section  
01:18 18 2552, in reaching your opinions and conclusions in this case?

01:18 19 A. That is the definition that I used.

01:18 20 Q. Now, you mentioned another policy, and I'm going to direct  
01:18 21 your attention to Government's Exhibit No. 7. I think you  
01:18 22 talked about the state medical boards.

01:18 23 A. Yes.

01:18 24 Q. You spent some time talking about revisions and updates,  
01:18 25 and the most recent one being in 2013; is that correct?

01:18 1 A. The most recent one to which I referred in this case, the  
01:18 2 most recent one is actually in 2019.

01:18 3 Q. So do you recognize what Government's Exhibit No. 7 is?

01:18 4 A. Yes.

01:19 5 Q. What is it?

01:19 6 A. It is The Federation of State Medical Board's Model Policy  
01:19 7 on Use of Opioid Analgesics and Treatment of Chronic Pain,  
01:19 8 revised July 2013.

01:19 9 Q. You indicated that Pennsylvania -- the Commonwealth of  
01:19 10 Pennsylvania is a signatory to this policy. What did you mean  
01:19 11 by that?

01:19 12 A. That is -- The Federation of State Medical Boards is a  
01:19 13 group that is comprised of the state medical boards of the  
01:19 14 various states and municipalities and territories of the United  
01:19 15 States, and 49 -- not all of the states are signatories to The  
01:19 16 Federation of State Medical Board's Model Policy, Pennsylvania  
01:19 17 is one of the states that is part of that organization.

01:19 18 Q. What does that mean to be a signatory?

01:19 19 A. It means that they've adopted the guidelines, as part of  
01:20 20 their medical board policy. The State Medical Board -- the  
01:20 21 Pennsylvania Medical Board initially sent out, in 1998, a copy  
01:20 22 of the model policy, and then in about 2009, they mailed to  
01:20 23 every practicing physician in the Commonwealth a book called  
01:20 24 Responsible Opioid Prescribing, and they have been part  
01:20 25 of -- this is part of the background guidance from the

01:20 1 Pennsylvania State Medical Board.

01:20 2 Q. Now, did you rely on the model policy on the use of opioid  
01:21 3 analgesics in the treatment of chronic pain in reaching your  
01:21 4 opinions and conclusions in this case?

01:21 5 A. Yes, it is one of the -- it is the guidance for  
01:21 6 appropriate prescribing, and it highlights areas of difficulty  
01:21 7 in opioid prescribing for physicians of which physicians would  
01:21 8 be aware.

01:21 9 Q. These guidelines in the definitional sections of certain  
01:21 10 codes, both in Pennsylvania and under the Federal realm, in  
01:21 11 your view, do they cater to the idiosyncrasies of physicians or  
01:21 12 are they objective? Are they allowed to cater to the  
01:21 13 idiosyncrasies of any particular physician?

01:22 14 A. Well, no, to the extent that medicine is a scientific  
01:22 15 practice, then, we must take the data that we gain through both  
01:22 16 experimentation, observation and experience and apply that to  
01:22 17 the treatment of patients. With respect to the prescribing of  
01:22 18 opioid analgesics, this has become part of the data of the  
01:22 19 public health milieu of the United States.

01:22 20 Q. What do you mean by that?

01:22 21 A. At the point at which we began to have the wave of opioid  
01:22 22 overdoses, leading to the declaration by Centers for Disease  
01:22 23 Control that we have a public health problem, which they  
01:22 24 labeled an opioid epidemic because of the high rate of use of  
01:22 25 the drugs, the high rate of complications in use of the drugs,

01:23 1 the harms associated with the high dose -- with the use of high  
01:23 2 dose opioids, that was so wide spread -- had become so wide  
01:23 3 spread that it impacts upon the public health.

01:23 4 Indeed, over the course of the last decade, we have seen  
01:23 5 the life expectancy of people in America fall, in part, related  
01:23 6 to deaths associated with the use of controlled substances.  
01:23 7 That is a public health problem.

01:23 8 And that public health problem is translated into both the  
01:23 9 guidance from the state medical board and the alerts to  
01:23 10 physicians that the iatrogenic part, the part for which we, as  
01:23 11 physicians, are responsible, is within our control and that we  
01:23 12 must, first, do no harm.

01:23 13 Q. In your opinion, Dr. Thomas, what is the hall mark, in  
01:24 14 your opinion, of practicing or issuing prescriptions, within  
01:24 15 the usual course of professional practice and for legitimate  
01:24 16 medical purposes?

01:24 17 A. Yes. To be able to identify that process, because it is  
01:24 18 not a point determination, it is a process, it is;

01:24 19 Has the physician taken appropriate history? Asked the  
01:24 20 patient the questions that are necessary, in order to determine  
01:24 21 whether or not the use of a controlled substance is  
01:24 22 appropriate? Has the physician gathered the information that  
01:24 23 comes in the form of physical examination, to determine whether  
01:25 24 or not the use of a controlled substance could be beneficial to  
01:25 25 the patient and what the effectiveness or lack thereof is of

01:25 1 the medication on the patient?

01:25 2 Has the physician appropriately observed those things that  
01:25 3 would be expected to be impacted by the use of the drug, in  
01:25 4 order to determine whether or not the drug is causing harm.

01:25 5 So, for example, in high dose opioid treatment, if someone  
01:25 6 is taking a lot of drug, I expect them to look like they're  
01:25 7 taking a lot of drug, and, therefore, I need to be watching  
01:25 8 for, Are they intoxicated? How do they walk? What are the hall  
01:25 9 marks of problematic drug use?

01:25 10 Further, Has the physician, particularly, in the period at  
01:25 11 hand, have they conducted satisfactory pharmacovigilance? By  
01:26 12 that is, are you being careful with the drug? Being careful  
01:26 13 with a controlled substance includes prescribing to the  
01:26 14 patients so that they don't have too much drug on hand and  
01:26 15 regularly, based upon the prescription.

01:26 16 It includes the occasional occurrence of a pill count.  
01:26 17 When the patient is using the drugs appropriately,  
01:26 18 occasionally, counting to make sure they are using what they're  
01:26 19 instructed to use and not using more than that. And the only  
01:26 20 way to determine that is to have them bring in their pills and  
01:26 21 you count them.

01:26 22 From time to time, depending upon the risk stratification  
01:26 23 of the patient, that is, some people and some drugs are riskier  
01:26 24 than other people and other drugs. So high doses of Methadone  
01:26 25 are riskier than low doses of oxycodone.

01:27 1 People who have a history of substance abuse, overdose,  
01:27 2 drug-seeking behavior or treatment for any of those things are  
01:27 3 high risk patients and, therefore, must be observed more  
01:27 4 frequently.

01:27 5 Among the clinical observations, as well as laboratory  
01:27 6 observations, is urine drug screening. Testing to see, Does the  
01:27 7 patient have the expected drug in their system with the absence  
01:27 8 of unexpected drugs? Urine drug screening provides objective  
01:27 9 evidence of the appropriate use of the drug by the patient and  
01:27 10 the appropriate non-use of the drug by the patient.

01:27 11 A urine drug screen is not a test that one passes or  
01:27 12 fails. A urine drug screen provides objective evidence that is  
01:27 13 either expected, the drug that the physician is prescribing is  
01:28 14 present, it's presents in reasonable quantities, without  
01:28 15 adulterants and is regularly present, and the drugs that the  
01:28 16 patient is not prescribed are not present or it's unexpected.  
01:28 17 Either of those things is not true.

01:28 18 Q. Now, in staying in that same line of approach that you  
01:28 19 have just testified to, how important is patient selection and  
01:28 20 individualized care? Are you familiar with those terms?

01:28 21 A. Absolutely.

01:28 22 Q. So could you please tell us what they are and how  
01:28 23 important they are?

01:28 24 A. So every article that I've read in the last 20 years,  
01:28 25 regarding the use of opioids for the treatment of chronic pain,

01:28 1 has contained a sentence that says, The use of opioids in the  
01:29 2 treatment of non-cancer pain is controversial. There is no  
01:29 3 clear evidence that these drugs are safe and effective for that  
01:29 4 purpose, or something to that effect.

01:29 5 Therefore, the axiom that some things work for some people  
01:29 6 some time is always applied to the use of these drugs. Being  
01:29 7 assured that a patient is appropriate for the use of the drug,  
01:29 8 achieves the expected effect, that is, that there is a decrease  
01:29 9 in pain intensity and increase in their function that is  
01:29 10 documented and that occurs with a reasonable dose of the drug,  
01:29 11 such that harm is not expected to occur.

01:29 12 It is, basically, the process of plucking the rose and  
01:29 13 leaving the thorns. Because we know with these drugs that the  
01:29 14 higher the dose, the more likely the harm. The longer the use  
01:30 15 the more likely the harm.

01:30 16 And if the patient is poorly selected, that is, someone  
01:30 17 who will not take the medications appropriately, who will abuse  
01:30 18 the medications, who has psychological difficulties with  
01:30 19 impulse control, which represent risk factors for non-medical  
01:30 20 use of the drug, all of those things increase the likelihood of  
01:30 21 harm, and anything that increases the likelihood of harm  
01:30 22 requires the physician to be more vigilant, more careful, and  
01:30 23 to minimize that potential harm, because everything about the  
01:30 24 practice and the public health information and the data that we  
01:30 25 have about the use of these drugs suggests that that is the

01:30 1 appropriate thing to do.

01:30 2 Q. So if you were to approach a patient's file and all you  
01:30 3 knew, right from the start -- if all you saw, right from the  
01:31 4 start, was high doses of opioids, as you would interpret high  
01:31 5 doses of opioids to be, over a long period of time, in your  
01:31 6 view, would that be -- would that cause you to look further?

01:31 7 A. Yes, and, in fact, doses greater than 19 milligrams of  
01:31 8 morphine equivalents is the initial point at which one begins  
01:31 9 to look further, and certainly, with doses greater than 200  
01:31 10 milligrams of morphine equivalents, we know that the patient,  
01:31 11 over the course of a 3 to 5 year period, has a three percent  
01:31 12 chance of death, and, therefore, is, on its face, it is a risky  
01:31 13 endeavor.

01:31 14 It should occur rarely, and, particularly, if it were  
01:31 15 occurring frequently, that would increase the likelihood that  
01:31 16 the prescribing was inappropriate at best.

01:32 17 Q. Now, when you are asked to determine the legitimacy of  
01:32 18 prescribing, do you rely on whether or not a patient says, "I  
01:32 19 liked what the doctor was prescribing for me"?

01:32 20 A. No, that's not a medical standard. Drug-liking is a -- it  
01:32 21 is a medical term, it is the term that we use for, if we give a  
01:32 22 patient a drug in a blinded fashion, how many people,  
01:32 23 particularly, those who have substance use disorder, will say,  
01:32 24 "I like that drug".

01:32 25 A patient liking what they are getting is not a medical

01:33 1 standard for determining legitimacy, the determination of  
01:33 2 legitimacy is based upon the practice of medicine, adequate  
01:33 3 history, adequate physical examination, appropriate  
01:33 4 pharmacovigilance and responding to the information that the  
01:33 5 physician gains about whether or not to write the next  
01:33 6 prescription.

01:33 7 Because if one doesn't do adequate history, physical  
01:33 8 examination, pharmacovigilance, testing, diagnosis, and one  
01:33 9 ignores the information gained, such that you're giving a drug  
01:33 10 to a patient who should not have it, based upon the practice of  
01:33 11 medicine that has preceded it, then, that prescription is not  
01:33 12 for a medically legitimate purpose in the usual course of  
01:33 13 professional practice, because it ignores the accepted  
01:33 14 treatment principles of any responsible segment of the medical  
01:34 15 community.

01:34 16 Q. What is risk mitigation in the prescribing of controlled  
01:34 17 substances?

01:34 18 A. We know risk, generally, is the probability of loss, the  
01:34 19 probability of a bad outcome. So how do we minimize the  
01:34 20 probability of a bad outcome for a patient who is prescribed  
01:34 21 controlled substances?

01:34 22 We do that by patient selection. We determine whether or  
01:34 23 not there are things about this patient that we know beforehand  
01:34 24 that would increase the likelihood of a bad outcome, a history  
01:34 25 of personal substance abuse, a history of alcohol abuse, heavy

01:34 1 cigarette smoking, other -- multiple other chronic diseases. A  
01:35 2 history of depression, anxiety or other psychological disorder  
01:35 3 are all things that increase the risk before the physician ever  
01:35 4 lays pen to paper, and all of those things are laid out in the  
01:35 5 literature regarding the prescribing of controlled substances  
01:35 6 on a chronic basis. And the drug, there's also risk inherent in  
01:35 7 the drug.

01:35 8       So as we have said, Methadone is riskier than other  
01:35 9 opioids because of its unique pharmacology. And higher doses  
01:35 10 are riskier than lower doses, so those are things that we can  
01:35 11 know before the fact.

01:35 12       After-the-fact risk mitigation is in that realm that I  
01:35 13 called pharmacovigilance. Urine drug screening, pill counts,  
01:35 14 and later, the prescription drug monitoring program of the  
01:36 15 Pennsylvania -- of the Pennsylvania Department of Health. That  
01:36 16 was not applied -- that particular circumstance was not applied  
01:36 17 to my evaluation of Kristina Dame, because, in 2013 and 2014,  
01:36 18 physicians did not have direct access to The Prescription Drug  
01:36 19 Monitoring Program. Physicians did not gain direct access to  
01:36 20 The Prescription Drug Monitoring Program until late 2015, and  
01:36 21 it became a requirement, prior to writing a benzodiazepine or  
01:36 22 opioid prescription in January of 2017.

01:36 23 Q.   Even though a physician didn't have direct access to the  
01:36 24 Prescription Drug Monitoring Program in 2014, was the drug  
01:36 25 monitoring program for Controlled II substances available in a

01:37 1 database in Pennsylvania in 2014?

01:37 2 A. It was.

01:37 3 Q. And does the fact that a physician can't access or could  
01:37 4 not access the PDMP directly from his desk in 2014, does it  
01:37 5 alter any of the previous guidelines or literature or policies  
01:37 6 that you have talked about, in terms of a physician's  
01:37 7 responsibility, when prescribing controlled substances?

01:37 8 A. No, it simply limits what we can reasonably presume that a  
01:37 9 physician knew, as a matter of fact.

01:37 10 Q. So could a physician simply ask a patient, What drugs are  
01:37 11 you taking?

01:37 12 A. That would be expected.

01:37 13 Q. What if a patient says, I'm not going to release my prior  
01:37 14 medical records to you, before you treat me. Have you been  
01:38 15 confronted with that, in your practice and experience? Is that  
01:38 16 typical?

01:38 17 A. It would be exceedingly atypical, but it would be a red  
01:38 18 flag on fire. If a patient is unwilling to provide you with the  
01:38 19 information about their prior treatment, particularly, with  
01:38 20 controlled substances, the only reason that I could imagine  
01:38 21 that occurring is that there's something that the patient  
01:38 22 doesn't want the physician to know.

01:38 23 Physicians are knowledge workers. Ignorance is not bliss  
01:38 24 in this profession. If one did not know, then, one would have  
01:38 25 to act as if that lack of knowledge represents knowledge of the

01:38 1 worst case scenario. Because, otherwise, all of the risk is in  
01:38 2 acting as if one knows. As my first teacher of medicine John  
01:39 3 Thomas taught me, He who knows not and knows not that he knows  
01:39 4 not is dangerous.

01:39 5 Q. And, in fact, one of the authorities that you have  
01:39 6 testified to, being a part of the Pennsylvania Code 49 Section  
01:39 7 1692, part of that prescribing and dispensing would be to  
01:39 8 obtain prior medical records?

01:39 9 A. Yes, and that is, also, in the Federation of State Medical  
01:39 10 Board's Model Policy.

01:39 11 Q. Now, in this case, you've testified that you had the  
01:39 12 benefit of reading a report of an interview with Kristina  
01:39 13 Dame's mother, that would be Margaret Dame; correct?

01:39 14 A. Yes.

01:39 15 Q. Was that, at all, informative to you, in reaching the  
01:39 16 opinions and conclusions that you reached?

01:39 17 A. It was another data point that allowed me to understand  
01:40 18 the circumstances in which the doctor was prescribing.

01:40 19 Q. Are you familiar with the term, differential diagnosis?

01:40 20 A. Yes.

01:40 21 Q. Can you please tell us what it means?

01:40 22 A. Differential diagnosis is the list that the physician  
01:40 23 develops, when confronted with a patient. We rarely know  
01:40 24 absolutely, from the first time we see a patient, precisely,  
01:40 25 everything that is going on. The differential diagnosis is,

01:40 1 Here are the things that could be going on, given the  
01:40 2 presentation of the patient that I have in front of me.

01:40 3 Q. Is it a fairly typical tool that's used in medicine?

01:40 4 A. Yes.

01:40 5 Q. And can they -- a differential diagnosis also be used to  
01:41 6 determine the cause of death?

01:41 7 A. Yes.

01:41 8 Q. Or, let's say, the cause of an unintended death?

01:41 9 A. Yes.

01:41 10 Q. Did you use a differential diagnosis in this case, in  
01:41 11 evaluating the records that were provided to you, in reaching  
01:41 12 an opinion regarding the cause of death in this case?

01:41 13 A. Yes.

01:41 14 Q. Can you explain to us how you did that?

01:41 15 A. Ms. Dame presented with a sudden -- with an unexpected  
01:41 16 death in a particular set of clinical circumstances. And just  
01:41 17 as the coroner who performed the postmortem did not reach a  
01:41 18 final diagnosis until after toxicology, it was the entirety of  
01:42 19 the presentation that I used in determining the cause of death  
01:42 20 with the but-for condition.

01:42 21 Ms. Dame had a history that was well-documented in the  
01:42 22 medical record of substance use, substance abuse and pain  
01:42 23 complaints associated with that as a means of obtaining further  
01:42 24 substances. And that was throughout the time that she was under  
01:42 25 Dr. Evers' care.

01:42 1 When she was found dead, the postmortem revealed no  
01:42 2 obvious cause of death, in terms of a hemorrhage or trauma or  
01:43 3 other internal organ dysfunction, but it did have an important  
01:43 4 physical finding, and that is, when the -- at the postmortem,  
01:43 5 there was frothiness in the mouth, and when he cut the lung,  
01:43 6 there was copious pulmonary edema fluid.

01:43 7 What that tells one is that, when the patient died, there  
01:43 8 was a lot of fluid in the lungs, and that is consistent with  
01:43 9 the deaths that occur when people become apneic, stop  
01:43 10 breathing, and, occasionally, try to breathe against a closed  
01:43 11 glottis, that is breathing in when your throat is closed off,  
01:43 12 because that produces negative pressure in the chest and pulls  
01:43 13 fluid into the lungs. It is a common thing to occur in  
01:43 14 anesthetics, in fact, or post-aesthetically, when patients are  
01:44 15 awakening, and you have to guard for it. But that's important  
01:44 16 information.

01:44 17 Then, when one obtains the toxicology, the toxicology  
01:44 18 showed that she had levels of drug in her blood, both a  
01:44 19 sedative hypnotic nordiazepam and Methadone, that were within  
01:44 20 the range that could produce both unconsciousness and closing  
01:44 21 of the airway, such as to provide a mechanism of death. She,  
01:44 22 incidentally, had a level of doxepin in her blood, as well,  
01:44 23 that would not have been directly contributory to her death, in  
01:44 24 the absence of the other drugs.

01:44 25 And thus, given the history, the postmortem examination

01:44 1 and the toxicology occurring in the setting of a patient who  
01:45 2 was treated in the way that Mrs. Dame was, that is, a patient  
01:45 3 who had been weaned off of opioid analgesics, between her last  
01:45 4 prescription from Dr. Evers of Methadone in July and her  
01:45 5 prescription of Methadone from Dr. Evers in September, she had  
01:45 6 gotten progressively lower doses of Methadone, to the extent  
01:45 7 that by the time he gave her her last prescription, she was,  
01:45 8 essentially, free of the drug.

01:45 9 So in that circumstances, a patient with a history of  
01:45 10 substance abuse, a patient who had loss of control, secondary  
01:45 11 to multiple risk factors associated with her use of the drugs,  
01:45 12 who had been weaned to reinstate her tolerance to the drugs,  
01:45 13 who died in a manner that was determined by the coroner to not  
01:46 14 be from other causes, had a level of drug in her blood,  
01:46 15 particularly, Methadone and nordiazepam, an active metabolite  
01:46 16 of diazepam, the drug that is in Valium, which Dr. Evers had  
01:46 17 also prescribed, that those things, along with her postmortem  
01:46 18 examination and the manner of prescribing, led me to the  
01:46 19 conclusion that but for the prescription of Methadone, 360 10mg  
01:46 20 tablets, to a patient who was relatively opioid naive, given to  
01:46 21 her weaning over the course of two months, that Ms. Dame would  
01:46 22 not have died.

01:46 23 Q. You mentioned that -- you mentioned the diazepam and the  
01:46 24 Methadone that was in the toxicology. I just want to speak to  
01:47 25 you, generally, about -- can you speak to the risk or increased

01:47 1 risk, when you have an opioid like Methadone and then you add a  
01:47 2 benzodiazepine, is there an increased risk, and if so, how  
01:47 3 much?

01:47 4 A. It is a problematic practicing of medicine that provides  
01:47 5 opioids and benzodiazepines to patients, given that both the  
01:47 6 prescribing information for the opioid and the prescribing  
01:47 7 information for the benzodiazepine and the medical literature  
01:47 8 of the past 30 years, all state that these drugs are  
01:47 9 potentially hazardous when they are used together.

01:47 10 They are especially hazardous when they are used together  
01:47 11 in patients who do not exhibit adequate control of their  
01:47 12 medication-taking behavior. We know that because of their  
01:48 13 varied mechanisms, Methadone and the opioids acting in the  
01:48 14 lower portion of the brain where breathing occurs, while the  
01:48 15 benzodiazepines and other sedatives act in the higher part of  
01:48 16 the brain where consciousness occurs, that, by blocking one and  
01:48 17 then the other, you enhance their effects, particularly, if  
01:48 18 consciousness is lost, and the airway is no longer protected.

01:48 19 The degree to which they increase the risk is actually  
01:48 20 only measured after the fact, so we know that in 30 percent of  
01:48 21 the cases in which opioid overdose is known to be the cause of  
01:48 22 death, benzodiazepines occur. Because of their very mechanisms,  
01:48 23 they clearly enhance the risk of death or overdose or  
01:48 24 intoxication or any of the other harms that occur with the use  
01:48 25 of opioids, falls, accidents and other injuries.

01:49 1 But by itself, the co-administration of the benzodiazepine  
01:49 2 is risky, it may be negligent, but because it is widespread, it  
01:49 3 is not itself not for a medically legitimate purpose in the  
01:49 4 usual course of professional practice, unless it's demonstrated  
01:49 5 that it's problematic for the patient.

01:49 6 Q. We talked about the but-for cause of death. In particular,  
01:49 7 in this case, based upon your training, your experience and  
01:49 8 consideration of the records that you reviewed, and in  
01:49 9 consideration of everything that you've testified to here  
01:49 10 today, were you able to reach an opinion regarding the cause of  
01:49 11 death of Kristina Dame?

01:49 12 A. Yes, it was clear, and I agreed with the coroner, that it  
01:49 13 was mixed drug toxicity. It is called mixed drug toxicity  
01:49 14 because there was more than one drug involved. The primary drug  
01:50 15 being involved in her cause of death was Methadone, and that  
01:50 16 because of the mechanism of death and what the postmortem  
01:50 17 showed and a secondary cause was the presence of the  
01:50 18 nordiazepam.

01:50 19 Q. Now, you've also talked a lot about the validity of the  
01:50 20 prescriptions and what a valid prescription is, in terms of the  
01:50 21 medical practitioner issuing it. Did you reach an opinion in  
01:50 22 this case about the whether or not the prescriptions that are  
01:50 23 identified in the indictment in this case were issued by the  
01:50 24 Defendant in the usual course of professional practice and for  
01:50 25 legitimate medical purposes?

01:50 1 A. Yes, I reached an opinion, and I believe they were not.

01:50 2 Q. Okay, and the opinion about the legitimacy of the  
01:50 3 prescriptions, as well as the but-for cause of death, did you  
01:51 4 include those opinions in your reports, which are identified as  
01:51 5 Government's Exhibit Nos. 2 and 3? And if you could refer to  
01:51 6 Exhibits Nos. 2 and 3, please.

01:51 7 And just for purposes of the record, can you first  
01:51 8 identify Government's Exhibit No. 2?

01:51 9 A. It is a report that I authored on August 12, 2019, United  
01:51 10 States Department of Justice v. Martin Evers, M.D.

01:51 11 Q. And Government's Exhibit No. 3?

01:51 12 A. It is a report that I authored on September 7, 2020,  
01:51 13 similarly labeled.

01:51 14 Q. The opinions that you have just testified to, have you  
01:51 15 included those opinions in your reports?

01:51 16 A. Yes.

01:51 17 Q. Now, in terms of the but-for cause of death, can  
01:51 18 you -- specifically talking about your background, your  
01:51 19 training and your experience as an anesthesiologist -- does  
01:52 20 that background and experience advance your opinions in this  
01:52 21 case, especially, when you're asked to render an opinion as to  
01:52 22 cause of death?

01:52 23 A. Yes.

01:52 24 Q. Can you explain to the Court how does that?

01:52 25 A. The drugs which we are discussing, opioids and sedative

01:52 1 hypnotics, are the cornerstone of anesthetic management. An  
01:52 2 anesthetic -- I'm sorry. My dad used to tease me that the  
01:52 3 reason I liked anesthesia was because I could dangle people  
01:52 4 over the chasm and then snatch them back.

01:52 5 An anesthetic is a controlled overdose. I have overdosed  
01:52 6 tens of thousands of patients deliberately and managed them  
01:52 7 after that occurred. I also, in treating patients, observed  
01:53 8 multiple overdoses. I've observed patients who have overdosed  
01:53 9 on Methadone in therapeutic concentrations. A patient, who I  
01:53 10 remember right now, who, when she was at 20 milligrams of  
01:53 11 Methadone twice a day, she was fine, at 30 milligrams, she  
01:53 12 stopped breathing.

01:53 13 My experience with these drugs is, frankly, at that region  
01:53 14 where patients overdose, where I've watched it happen  
01:53 15 repeatedly and managed them through it. So when I read what is  
01:53 16 happening here and I look at the blood levels and I look at the  
01:53 17 combinations, those are not dissimilar to my experience as an  
01:53 18 anesthesiologist, but, in fact, they are -- they have been part  
01:53 19 of my practice in outpatient medicine, in terms of minimizing  
01:54 20 those risks to my own patients.

01:54 21 It is certainly within the realm of all of my practice,  
01:54 22 over the course of the past 35 years that I draw from, and I  
01:54 23 base it upon the scientific principles of the practice of  
01:54 24 medicine that I've gleaned over that time.

01:54 25 Q. Now, Dr. Thomas, are you aware of any change in the law

01:54 1 that occurred in 2018, 2019 or thereafter that prohibited  
01:54 2 physicians from prescribing opioids?

01:54 3 A. None. The standards of practice -- frankly, the standards  
01:54 4 of practice in that period were relatively stable. There had  
01:54 5 been no particular changes since the introduction of the CDC  
01:55 6 guide of 2016.

01:55 7 Q. Now, you mentioned the CDC, so I want to just refer your  
01:55 8 attention to one last exhibit, which is Government's Exhibit  
01:55 9 No. 9 in the binder. You talked about MME's, the Morphine  
01:55 10 Milligram Equivalents, and at one point, you were talking about  
01:55 11 a Morphine Milligram Equivalency of, I think you said, about  
01:55 12 1100 or 1200 a day. Do you recall that?

01:55 13 A. Um-hum.

01:55 14 Q. Are there -- has the CDC issued recommendations for  
01:55 15 Morphine Milligram Equivalents per day that are considered safe  
01:55 16 and advisories about exceeding the safe limits that you're  
01:55 17 familiar with?

01:55 18 A. The CDC Guideline states that the best dose is the lowest  
01:55 19 dose that the patient can tolerate that is consistent with  
01:55 20 analgesia and improved function for the shortest period of  
01:56 21 time. They identify several inflection points of risk.

01:56 22 Between 1 and 20 milligrams of Morphine equivalence is  
01:56 23 deemed the safest level of risk. There is an increased risk  
01:56 24 between 20 milligrams and 50 milligrams, but there's also  
01:56 25 evidence that, even in chronic non-cancer pain, there's a

01:56 1 modest increase in effectiveness in that range.

01:56 2 Up to 19 milligrams, there is another inflection point in  
01:56 3 risk, but there's, also, a lack of any evidence in the medical  
01:56 4 literature at greater than 19 milligrams of Morphine  
01:56 5 equivalence of an improvement in efficacy, in terms of an  
01:56 6 improvement in both pain intensity and function.

01:56 7 At 200 milligrams is the next inflection point, where we  
01:56 8 see -- 200 milligrams of Morphine equivalence -- where we see a  
01:56 9 clear inflection point, in terms of another increase in risk,  
01:57 10 with the risk of death increasing to more than 32 over the  
01:57 11 course of three to five years.

01:57 12 Q. That would be at 200 Morphine milligram equivalencies and  
01:57 13 more?

01:57 14 A. Yes.

01:57 15 Q. Even at more than 20 Morphine milligram equivalencies a  
01:57 16 day, there's a risk?

01:57 17 A. Yes, the risk begins to increase for all harms associated  
01:57 18 with the drug, not just the risk of overdose and death, but the  
01:57 19 risk of falls, fractures, endocrinopathies, that is,  
01:57 20 suppression of the pituitary gland, and other harms associated  
01:57 21 with the drug.

01:57 22 Q. Can you take a look at Government Exhibit No. 9 and tell  
01:57 23 us if you recognize that?

01:57 24 A. I do.

01:57 25 Q. And is this the directives or what you just testified to

01:57 1 about the risks and the MME's of greater than 20 per day, does  
01:57 2 this Exhibit No. 9 speak to that?

01:57 3 A. Yes.

01:57 4 Q. Did you rely on information such as this, provided by the  
01:58 5 CDC, in reaching the opinions that you reached in this case?

01:58 6 A. Yes.

01:58 7 Q. Now, do those same MME's and that guidance apply to, let's  
01:58 8 say, someone who is dying of cancer and who is in hospice?

01:58 9 A. No.

01:58 10 Q. Why?

01:58 11 A. The CDC in their guidelines of March 2019, specifically,  
01:58 12 state that it is applied to chronic non-cancer pain, which has  
01:58 13 different mechanisms and underlying fundamentals than chronic  
01:58 14 cancer pain.

01:58 15 Cancer pain, I always -- I describe as -- the difference  
01:58 16 between chronic non-cancer pain and cancer pain is, chronic  
01:58 17 non-cancer pain is a pebble in your shoe. Chronic cancer pain  
01:58 18 is someone with a knife cutting into your foot. The  
01:58 19 invasiveness, the metastases, the changing nature of the  
01:59 20 underlying tumor makes cancer pain exceedingly different, and  
01:59 21 frequently, the issue of duration of life makes a very big  
01:59 22 difference because most people with back pain do not die of  
01:59 23 back pain, while we may be dealing with end of life  
01:59 24 circumstances in patients with cancer.

01:59 25 So there are very different, both morally,

01:59 1 philosophically, physiologically types of pain syndromes than  
01:59 2 the problem of non-cancer pain that we're talking about when we  
01:59 3 discuss these issues. And, in fact, when I review cases like  
01:59 4 this, if I see a patient who has cancer pain who is included, I  
01:59 5 will exclude them, because I would have to use a totally  
01:59 6 different set of paradigms, in order to evaluate that  
01:59 7 prescribing.

02:00 8 Q. Having said all of that, Dr. Thomas, in the opinions that  
02:00 9 you have expressed from the stand, as well as in your reports,  
02:00 10 can you tell us whether or not you hold those opinions to a  
02:00 11 reasonable degree of medical certainty?

02:00 12 A. I hold each and every opinion that I have expressed within  
02:00 13 a reasonable degree of medical certainty.

02:00 14 MS. OLSHEFSKI: Your Honor, at this time, I would move  
02:00 15 admission of Government's Exhibit Nos. 2 and 3, No. 2 being  
02:00 16 Dr. Thomas' April 12, 2019 report, No. 3 being Dr. Thomas'  
02:00 17 September 7, 2020 report.

02:00 18 THE COURT: Any objection to Government's 2 and 3?

02:00 19 MR. BRIER: No objection, Your Honor.

02:00 20 MS. OLSHEFSKI: Your Honor, I would also move for admission  
02:00 21 of the authorities relied upon in Government's Exhibit 4, which  
02:01 22 is Title 28 Pennsylvania Code Chapter 25; Exhibit No. 5, which  
02:01 23 is 21 CFR 1306.04; Exhibit No. 6, which is Title 21 United  
02:01 24 States Code Section 829 defining Prescriptions; Exhibit No. 7,  
02:01 25 which is the Model Policy on Use of Opioid Analgesics and the

02:01 1 Treatment of Chronic Pain; Exhibit No. 8, which is Title 49  
02:01 2 Pennsylvania Code Section 1692 defining Prescribing,  
02:01 3 Administering and Dispensing of Controlled Substances;  
02:01 4 Government's Exhibit No. 9, which is the CDC Opioid Guidance in  
02:01 5 terms of MME's, which was just referenced by Dr. Thomas, and  
02:01 6 then Exhibit No. 10, I think that's already been admitted, that  
02:01 7 is the Methadone package insert.

02:01 8 THE COURT: Mr. Brier, any objection to any of those  
02:01 9 exhibits identified?

02:01 10 MR. BRIER: No objection, Your Honor.

02:02 11 THE COURT: All right, Government's 2, 3, 4, 5, 6, 7, 8, 9  
02:02 12 and 10 are admitted.

02:02 13 (At this time Government's Exhibit Nos. 2-9 were admitted  
02:02 14 into evidence.)

02:02 15 MS. OLSHEFSKI: Your Honor, for purposes of the Daubert  
02:02 16 hearing, the Government has no further questions on direct for  
02:02 17 Dr. Thomas.

02:02 18 THE COURT: Let's take 15 minutes and then we can continue.

02:02 19 (At this time a recess was taken.)

02:20 20 THE COURT: Counsel, I understand there's an issue you'd  
02:20 21 like to discuss with me before we proceed any further?

02:20 22 MR. CASEY: Yes, Your Honor. I'd appreciate a few minutes.

02:20 23 Procedurally, we have for the search warrant issue, both  
02:20 24 probable cause and Franks, we have witnesses coming from out of  
02:20 25 the area, about an hour out of the area, some of them are

02:20 1 disabled, some of them are people with families, and so we  
02:20 2 would propose to the Court, instead of proceeding to the  
02:20 3 probable cause section and having Diversion Investigator Derr  
02:20 4 testify, we get to those who have come in to testify regarding  
02:20 5 the Franks matter, and so they would follow the expert  
02:20 6 testimony here, with one exception, there's one person on  
02:20 7 standing that the Government wishes to call.

02:20 8 So, simply put, we're apprising the Court of what we would  
02:21 9 suggest the appropriate order to be for calling witnesses, and  
02:21 10 then secondarily -- or not secondarily -- but, also, the  
02:21 11 Assistant U.S. Attorney wanted to broach with the Court, I  
02:21 12 think, the relevancy issue or admissibility issue, with respect  
02:21 13 to some of the witnesses. I won't make her argument, Judge,  
02:21 14 I'll sit tight on that.

02:21 15 THE COURT: Am I to understand that you want to conduct  
02:21 16 this particular aspect of the other suppression motion before  
02:21 17 we return to Dr. Thomas?

02:21 18 MR. CASEY: No, Your Honor, this would follow Dr. Thomas.

02:21 19 THE COURT: All right, let's see where we are, after we  
02:21 20 conclude the Daubert hearing, and we can talk about these  
02:21 21 things, but I think it's a bit premature. We have a lot to do  
02:21 22 here, right now, and I'm reluctant to spend any more time on  
02:21 23 it. So with that, Mr. Brier, you can cross-examine.

02:22 24 MR. BRIER: Thank you, Your Honor. Frank Brier, on behalf  
02:22 25 of Dr. Martin Evers.

## CROSS EXAMINATION

BY MR. BRIER:

Q. Good afternoon, Doctor. How are you?

A. Good afternoon. How are you?

Q. Good, thanks. You've been up there a little while, and we have just taken a short break, so we're going to go forward if you're ready. Are you ready?

A. Certainly.

Q. Doctor, you went over with counsel for the Government your curriculum vitae. Do you have a copy in front of you there?

A. I do.

Q. You testified on direct examination, Doctor, that that was a current copy of your curriculum vitae; is that correct?

A. Yes.

Q. And you, during the course of your professional career, from time to time, you update that and keep that as a complete list of your professional activities; correct?

A. Yes.

Q. And, Doctor, in there, you indicate that you were a resident in Anesthesiology and a Fellow in Pain Medicine and Regional Anesthesiology. We covered that; correct?

A. That is correct.

Q. You mentioned on direct examination, during your residency, that you were involved in Critical Care Medicine, but you were not doing a residency in Critical Care Medicine;

02:23 1 correct?

02:23 2 A. No, I was doing a residency in Anesthesiology, and part of  
02:23 3 Anesthesiology, particularly, at Hopkins, is Critical Care  
02:23 4 Medicine, because we are the department or were the Department  
02:23 5 of Anesthesiology and Critical Care Medicine.

02:23 6 Q. Correct. My question was, simply, it wasn't a residency in  
02:23 7 Critical Care Medicine, you rotated through various  
02:23 8 subspecialties as an anesthesiologist, during your residency;  
02:23 9 correct?

02:23 10 A. Including Critical Care, yes.

02:23 11 Q. Including Labor and Delivery; correct?

02:23 12 A. Yes.

02:23 13 Q. Doctor, you testified on direct examination that from 2000  
02:23 14 to the present, you're CEO and President of Pain and Disability  
02:23 15 Management Consultants PC in Pittsburgh; correct?

02:23 16 A. Yes.

02:23 17 Q. Doctor, what percentage of your current practice is  
02:23 18 medical/legal?

02:24 19 A. 90 to 95.

02:24 20 Q. 90 to 95 percent in court?

02:24 21 A. Actually, it would be 100 percent if you include the  
02:24 22 Worker's Compensation and the patients I see for Worker's  
02:24 23 Compensation and personal injury evaluations.

02:24 24 Q. For disability evaluations for Worker's Comp, you're not  
02:24 25 treating those patients, you're just evaluating them; correct?

02:24 1 A. That is correct, I no longer have a current clinical  
02:24 2 practice.

02:24 3 Q. You haven't had an active clinical practice of medicine  
02:24 4 since June 30 of 2014; correct?

02:24 5 A. That is correct.

02:24 6 Q. So for the past seven years, you've been engaged 100  
02:24 7 percent of your time in medical/legal reviews; is that correct?

02:24 8 A. Six and a half.

02:24 9 Q. I'm sorry, I didn't mean to talk over you.

02:24 10 A. Six and a half, yes.

02:24 11 Q. Well, it be seven June 30th of this year; correct?

02:24 12 A. Correct.

02:24 13 Q. You testified on direct examination a number of times  
02:24 14 about the presentations that you have done in court in  
02:25 15 medical/legal analysis and expert opinions, and you testified  
02:25 16 that on, at least, two occasions, you reviewed cases on behalf  
02:25 17 of Defendants in criminal matters, but they did not call you as  
02:25 18 a witness; correct?

02:25 19 A. Yes.

02:25 20 Q. So the only times that you have attended court to testify  
02:25 21 in criminal matters, you've always been on behalf of the  
02:25 22 prosecution; correct?

02:25 23 A. That is correct.

02:25 24 Q. In fact, you have three open current cases with the  
02:25 25 prosecution, I think, in the Middle District; is that correct?

02:25 1 A. I can only think of two right now, but there are other  
02:25 2 things that I read that are not ripe.

02:25 3 Q. And you testified earlier that you're a Certified  
02:25 4 Independent Medical Examiner, and that Board that certifies  
02:25 5 Independent Medical Examiners, that's really a certification  
02:25 6 that you hold so that you can do these medical/legal IME  
02:26 7 reviews; correct?

02:26 8 A. No, I could do them without it, I do it, in order to  
02:26 9 demonstrate my competency in doing them.

02:26 10 Q. Fair enough. So you can still do them, even if you're not  
02:26 11 Board certified in IME's, but you got that as an added  
02:26 12 credential; correct?

02:26 13 A. Yes.

02:26 14 Q. But you're not a medical examiner in the sense that a  
02:26 15 pathologist is a medical examiner?

02:26 16 A. I am not. I tried to make that plain.

02:26 17 Q. During the period of time before June 30 of 2014, when you  
02:26 18 were, actually, clinically, treating patients, you were not in  
02:26 19 a community-based primary care practice, correct, you were in  
02:26 20 this pain specialty practice?

02:26 21 A. I've never been a primary care physician.

02:26 22 Q. You're not Board certified as a primary care physician;  
02:26 23 correct?

02:26 24 A. No.

02:26 25 Q. You never had privileges as a primary care physician;

02:26 1 correct?

02:26 2 A. No.

02:26 3 Q. That is correct, you have not?

02:27 4 A. That is, no, I have not.

02:27 5 Q. You never completed any residency in primary care?

02:27 6 A. I have not.

02:27 7 Q. You had mentioned on direct examination, Doctor, that you

02:27 8 have a Competency Certification in Controlled Substance

02:27 9 Management. Did I read that correctly?

02:27 10 A. That is correct.

02:27 11 Q. And that was in 2008; correct?

02:27 12 A. Yes.

02:27 13 Q. You've not re-certified or you've not re-established that

02:27 14 credential?

02:27 15 A. I have not. The drugs have not changed.

02:28 16 Q. Well, the practice has changed, you've talked about that

02:28 17 on multiple occasions today, since 1996, when they started

02:28 18 giving opioids for chronic pain, through 2011, when there was

02:28 19 this, as you said, cornerstone change -- I'm sorry -- 2011;

02:28 20 correct?

02:28 21 A. Yes.

02:28 22 Q. So the medications haven't changed, Doctor, but the way

02:28 23 the medications are used have changed; isn't that correct?

02:28 24 A. Yes, and I remain current with that.

02:28 25 Q. You're a member of the American Medical Association;

02:28 1 correct?

02:28 2 A. Among other institutions, yes.

02:28 3 Q. You're familiar with their model guidelines, and you would  
02:28 4 not be giving expert testimony in an area or specialty on which  
02:28 5 you have not had substantial practice; correct?

02:28 6 A. That is correct. And controlled substances is just that  
02:28 7 area for me.

02:28 8 Q. Controlled substances; correct?

02:28 9 A. Yes.

02:28 10 Q. Not primary care?

02:28 11 A. I have not testified as the primary care, I've testified  
02:28 12 as to the standard for any physician practicing in the United  
02:29 13 States or the Commonwealth of Pennsylvania.

02:29 14 Q. We understand, but from your review of the records, you  
02:29 15 know that Dr. Marty Evers was a primary care community-based  
02:29 16 physician; correct?

02:29 17 A. Yes. And the standards for primary care physicians in the  
02:29 18 prescription of controlled substances is precisely the same as  
02:29 19 it is for any physician in the prescription of controlled  
02:29 20 substances.

02:29 21 Q. Doctor, you also gave us a list of your publications. You  
02:29 22 have two publications, one is dated 2015 and one is dated 1988;  
02:29 23 correct?

02:29 24 A. That is correct.

02:29 25 Q. So with the exception of those two publications, you have

02:29 1 no other publications on any of the subjects that we're talking  
02:29 2 about today?

02:29 3 A. I have not published, no.

02:29 4 Q. So, for example, you have no peer-reviewed publications on  
02:30 5 drug death investigations?

02:30 6 A. That is correct.

02:30 7 Q. You have no peer-reviewed publications on the manner of  
02:30 8 death?

02:30 9 A. That is correct.

02:30 10 Q. You have no peer-reviewed publications, Doctor, on  
02:30 11 opioid-related deaths; correct?

02:30 12 A. As you noted, I have two publications. They are listed.

02:30 13 Q. Well, we have talked about a lot on direct examination,  
02:30 14 and these subjects came up, so I just want to ask you if you  
02:30 15 have any peer-reviewed evidence-based publications anywhere  
02:30 16 that I don't know about, on any of the subjects that we have  
02:30 17 talked about, Doctor?

02:30 18 A. No.

02:30 19 Q. You do not have any publications on comprehensive death  
02:30 20 investigations; correct?

02:30 21 A. Correct.

02:30 22 Q. You have no publications on opioid death with Long QT  
02:30 23 Syndrome; correct?

02:30 24 A. Correct.

02:30 25 Q. That's a cardiology issue, isn't it, Long QT Syndrome?

02:30 1 A. It's a cardiology issue that, certainly, is one that  
02:30 2 physicians prescribing Methadone must be aware.

02:30 3 Q. Sure, but it's a cardiac issue, it's an arrhythmia;  
02:31 4 correct?

02:31 5 A. If the prescriber is prescribing Methadone, they must be  
02:31 6 aware of it.

02:31 7 Q. Sure, and you mentioned that on your direct examination as  
02:31 8 something to be aware of if you're prescribing Methadone. But  
02:31 9 you have no publications on Sudden Death or Long QT Syndrome or  
02:31 10 cardiac arrhythmias, related to Methadone administration;  
02:31 11 correct?

02:31 12 A. No, I've simply observed it, and I'm passing on the  
02:31 13 information that I've read about it.

02:31 14 Q. Doctor, you have no publications on volatile organic  
02:31 15 solvent inhalation, do you?

02:31 16 A. No.

02:31 17 Q. You read the pathology report in this case and you read  
02:31 18 the medical records in this case, and you know that Kristina  
02:31 19 Dame had a chronic problem with solvent inhalation; correct?

02:31 20 A. Yes.

02:31 21 Q. It's mentioned in many places in her records and in the  
02:31 22 police reports; correct?

02:31 23 A. That is correct.

02:31 24 Q. It's also mentioned in the postmortem; correct?

02:31 25 A. Yes, it is.

02:31 1 Q. Doctor, in your practice, I'm sure, seven years ago, when  
02:31 2 you were treating patients, you treated patients who, also,  
02:32 3 were treating with anti-depressants; correct?

02:32 4 A. Yes.

02:32 5 Q. You also would see patients who were on antibiotics;  
02:32 6 correct?

02:32 7 A. Yes.

02:32 8 Q. But your primary focus was the pain medication; correct?

02:32 9 A. No.

02:32 10 Q. You would have to incorporate those other things into the  
02:32 11 treatment of the individual patient; correct?

02:32 12 A. Well, some of those, I would prescribe. For example,  
02:32 13 anti-depressants are first line agents for neuropathic pain and  
02:32 14 are anticonvulsants.

02:32 15 Q. What about antibiotics?

02:32 16 A. Antibiotics are not.

02:32 17 Q. So you wouldn't prescribe antibiotics?

02:32 18 A. I would prescribe antibiotics if it were necessary for a  
02:32 19 condition with which the patient presented to me.

02:32 20 Q. But that wouldn't be a normal or standard part of your  
02:32 21 practice in pain medicine, would it? You would refer the  
02:32 22 patient back to their primary care physician; correct?

02:32 23 A. Well, actually, when I was performing implantations and  
02:32 24 patients presented with wound infections, I would frequently  
02:32 25 provide them with antibiotics or if a patient presented to me

02:32 1 and they had a need for antibiotic, I would begin the  
02:33 2 prescription and then refer them to a primary care or to  
02:33 3 another physician, but antibiotics are part of the practice of  
02:33 4 medicine.

02:33 5 Q. Understood. Thank you for that clarification. I was  
02:33 6 thinking -- I wasn't thinking of the interventional part of  
02:33 7 your pain practice, where you do implants and injections;  
02:33 8 correct?

02:33 9 A. That is correct.

02:33 10 Q. Doctor, have you ever done an autopsy?

02:33 11 A. Yes.

02:33 12 Q. You've done autopsies, yourself?

02:33 13 A. I have not done an autopsy since 1983, but yes, I've done  
02:33 14 20 autopsies.

02:33 15 Q. So you did autopsies during your training?

02:33 16 A. Yes.

02:33 17 Q. But you never had privileges as a pathologist at a  
02:33 18 hospital?

02:33 19 A. No.

02:33 20 Q. You were never in the Department of Pathology in a  
02:33 21 hospital?

02:33 22 A. No.

02:33 23 Q. You never had privileges as a toxicologist in a hospital?

02:33 24 A. No.

02:33 25 Q. You never practiced as a toxicologist?

02:33 1 A. No.

02:33 2 Q. You never had a Fellowship or residency training as a  
02:33 3 toxicologist?

02:33 4 A. That is correct.

02:33 5 Q. And, in fact, in this case, Doctor, you had to call the  
02:33 6 toxicologist and ask him what he meant by the SA's. You put  
02:34 7 that in your report, isn't that right?

02:34 8 A. I asked him for clarification, yes.

02:34 9 Q. Do you have notes from that conversation, Doctor?

02:34 10 A. I do not.

02:34 11 Q. So you called Dr. Coyer, in this case, and you asked him  
02:34 12 what part of his report meant, but you didn't write any notes  
02:34 13 down or provide us that in your report; correct?

02:34 14 A. That is correct. I put the evidence of it in my report, as  
02:34 15 I mentioned.

02:34 16 Q. Did you ever call Dr. Ross and talk to him? He was the  
02:34 17 forensic pathologist that did the autopsy.

02:34 18 A. I did not call the forensic pathologist that did the  
02:34 19 autopsy.

02:34 20 Q. Are you familiar with term, autolysis, Doctor?

02:35 21 A. Yes.

02:35 22 Q. You have no publications on autolysis; correct?

02:35 23 A. No.

02:35 24 Q. Are you familiar, Doctor, with postmortem redistribution?

02:35 25 A. I am.

02:35 1 Q. You have no publications or lectures on postmortem  
02:35 2 redistribution, do you?

02:35 3 A. I do not.

02:35 4 Q. Do you know, in this case, Doctor, from where they drew  
02:35 5 the blood that was the subject of the exam?

02:35 6 A. I believe it's noted as femoral, but right now, I cannot  
02:35 7 tell you, at this moment, without referring back to the  
02:35 8 findings.

02:35 9 Q. We'll come back to that. You believe it was femoral?

02:35 10 A. At this moment, I do not know.

02:35 11 Q. So we'll come back to that. Do you know how long she was  
02:35 12 dead, before they did the blood draw?

02:35 13 A. I noted it, but I cannot tell you from memory. And, in  
02:35 14 fact, the precise time of death is not known, as she was  
02:36 15 unattended.

02:36 16 Q. Right, so there was a time of death that was official that  
02:36 17 was about 7 a.m., but the last time she had been seen alive was  
02:36 18 about 9:00 the night before. Does that sound right to you?

02:36 19 A. That is correct.

02:36 20 Q. Between 9 p.m. and 7 a.m. we don't know how long she was  
02:36 21 dead in that period of time; correct?

02:36 22 A. That is correct.

02:36 23 Q. Doctor, are you familiar with lividity?

02:36 24 A. Yes.

02:36 25 Q. Did you notice or is anywhere mentioned in, either, the

02:36 1 State Police report or the postmortem report that the body had  
02:36 2 lividity or rigor mortis?

02:36 3 A. Yes, it was mentioned she was in rigor and she had  
02:36 4 posterior lividity.

02:36 5 Q. Lividity, meaning, that she had been sitting in that chair  
02:36 6 long enough to form lividity on her backside; correct?

02:36 7 A. That was the report, yes.

02:36 8 Q. You said a minute ago, Doctor, that you did autopsies back  
02:36 9 during your training. What percentage of your practice in  
02:36 10 Pittsburgh was dedicated to performing postmortem examinations  
02:37 11 or autopsies?

02:37 12 A. Zero, obviously.

02:37 13 Q. Doctor, what's evidence-based medicine?

02:37 14 A. Evidence-based medicine is the attempt to practice  
02:37 15 medicine, in accordance with the best available evidence, based  
02:37 16 upon a grading of that evidence from the randomized controlled  
02:37 17 clinical trial to expert opinion and consensus.

02:37 18 Q. So if I understand you correctly -- and forgive me, I'm a  
02:37 19 layperson -- you said, earlier, you translate into layperson.  
02:37 20 Evidence-based medicine -- and you can correct me if I'm wrong  
02:37 21 -- is the practice of medicine based on peer-reviewed studies  
02:38 22 of clinical outcomes; correct?

02:38 23 A. No.

02:38 24 Q. What is it? You tell me.

02:38 25 A. It is the practice of medicine, based upon the best

02:38 1 available information, with a grading of that information from  
02:38 2 randomized double-blind placebo-controlled clinical trials to  
02:38 3 the least of that information, which is direct observation by  
02:38 4 individuals.

02:38 5 So all of that is still evidence, we simply attempt to use  
02:38 6 the best evidence available for any given purpose to which we  
02:38 7 need to apply it.

02:38 8 Q. Okay, so and the evidence is deemed weak or strong,  
02:38 9 depending on where that evidence is coming from; correct?

02:38 10 A. Yes.

02:38 11 Q. And the clinical studies, especially, the double-blind  
02:38 12 random clinical studies, they're considered strong evidence,  
02:38 13 correct, anecdotal evidence would be a little weaker; correct?

02:38 14 A. That is correct.

02:38 15 Q. Doctor, you testified on direct examination, very briefly,  
02:39 16 about a CDC Guidelines from 2016. But we can all agree we're  
02:39 17 talking about 2014 in all of these questions; correct?

02:39 18 A. That is correct.

02:39 19 Q. So, you know, even according to the AMA Guidelines, you  
02:39 20 should apply the standards that apply, at the time of the  
02:39 21 event; correct?

02:39 22 A. That is what I said on direct.

02:39 23 Q. And the guidelines are guidelines, they're not -- I don't  
02:39 24 think the practice of medicine has evolved, yet, to the point  
02:39 25 where it's a recipe or cookie-cutter approach, where you just

02:39 1 look up the patient and it tells you what to do, correct,  
02:39 2 there's still medical judgment involved?

02:39 3 A. That is what I said on direct.

02:39 4 Q. And, in fact, you said, when you review cases, you look at  
02:39 5 the sources of law, and you look at the records and you apply  
02:39 6 your judgment, training and experience to those sources;  
02:39 7 correct?

02:39 8 A. I didn't understand the first thing you said. Sources of  
02:39 9 law?

02:39 10 Q. Well, you talked about the CFR, the PA Code, you look at  
02:40 11 those as part of your methodology, and then you look at the  
02:40 12 records and you apply this judgment that you have to make an  
02:40 13 opinion; correct?

02:40 14 A. Yes.

02:40 15 Q. So the guidelines are really structured for physicians to  
02:40 16 understand what would be, I guess, a general application to the  
02:40 17 clinical presentation, but we can't have guidelines that  
02:40 18 anticipate every conceivable clinical scenario; correct?

02:40 19 A. No, guidelines do not anticipate every conceivable  
02:40 20 scenario, however, they give us general direction for normative  
02:40 21 physician behavior, relative to a particular area.

02:40 22 Q. Right, they give us general guidelines, right, and that's  
02:40 23 what they're called?

02:40 24 A. Yes.

02:40 25 Q. Doctor, in this case -- and you went over it in your

02:41 1 direct examination -- you authored two reports; correct?

02:41 2 A. Yes.

02:41 3 Q. August 12 of 2019 and September 7, 2020; correct?

02:41 4 A. That is correct.

02:41 5 Q. And when you're doing those reports, Doctor, it's your

02:41 6 practice to be inclusive and comprehensive as you can with

02:41 7 those reports, as to inform the folks of the basis, the

02:41 8 methodology and foundation of your opinion; correct?

02:41 9 A. Yes.

02:41 10 Q. In fact, Doctor, you would agree with me you want to

02:41 11 review the records so you get the clearest possible picture of

02:42 12 the clinical scenario; correct?

02:42 13 A. I review the records that are available and always

02:42 14 conclude by saying that, if additional information becomes

02:42 15 available that would impact my opinion, I will respond to it.

02:42 16 Q. All right, but that wasn't exactly what my question was,

02:42 17 Doctor, and I apologize if I didn't ask it clearly.

02:42 18 My question was, you would prefer to have all of the

02:42 19 records, so that you get the clearest possible picture of the

02:42 20 events that you're opining about; correct?

02:42 21 A. I would prefer to know everything, and then I would know

02:42 22 everything. However, the limitations of any review are what's

02:42 23 available, at the time, and if any additional information would

02:42 24 change that, then, I would incorporate it, when provided.

02:42 25 Q. Doctor, again, I apologize if I'm not asking the question

02:42 1 clearly. I can ask it again.

02:42 2 You want to have as much of the records as you possibly  
02:43 3 can to have the foundation for your opinion; correct? You want  
02:43 4 to have all of the --

02:43 5 A. You're asking me about -- what you're asking me is what  
02:43 6 would I desire, and what I desire is irrelevant. What I had is  
02:43 7 what I had, what I responded to is what I was given. What I  
02:43 8 want is never part of the process.

02:43 9 Q. Doctor, you were expressly critical of Dr. Evers for not  
02:43 10 availing himself of all of the records. Did you avail yourself  
02:43 11 of all of Doctor's records, before you opined on your first  
02:43 12 report?

02:43 13 A. I availed myself of all the records that I had, and the  
02:43 14 difference between my criticism of Dr. Evers for not availing  
02:43 15 himself of the records is that I was not treating a live person  
02:43 16 in front of me.

02:43 17 Q. Well, we'll get to that in a minute. But you got the  
02:43 18 records that were sent to you by the Government; correct?

02:43 19 A. That's what I had.

02:43 20 Q. You didn't go out and find those records, yourself, you  
02:43 21 relied on the Government to provide you with the records that  
02:44 22 you reviewed, when you authored your first report; correct?

02:44 23 A. Of course, I relied upon the Government, because I have no  
02:44 24 right to the records, other than the ones that they gave me.

02:44 25 Q. Right, so if you got an incomplete set of records from the

02:44 1 Government, that came from the Government, that's not your  
02:44 2 doing; correct?

02:44 3 A. That is correct.

02:44 4 Q. When you do a peer-reviewed journal entry, as you have  
02:44 5 done two, one of the things you would do, I would imagine, is  
02:44 6 you would list all of the materials that you reviewed, so that  
02:44 7 when the peer reviewers are looking at your process and your  
02:44 8 outcomes, they know the specific foundations of the material  
02:45 9 you reviewed; correct?

02:45 10 A. That's not correct.

02:45 11 Q. How would that not be correct, Doctor?

02:45 12 A. Well, one of the articles was peer-reviewed in  
02:45 13 anesthesiology, the other was an editorial. So what one would  
02:45 14 do is submit the paper along with bibliography, and the  
02:45 15 bibliography would represent the information that was preceding  
02:45 16 it and would be footnoted in the actual text of the article.

02:45 17 Q. Fair enough. So you have one peer-reviewed article in  
02:45 18 anesthesia; correct?

02:45 19 A. Yes.

02:45 20 Q. In that article, I would imagine, you listed for the  
02:45 21 reviewer the information, the sources of the information you  
02:45 22 relied on in forming or writing your article; correct?

02:45 23 A. We wrote the abstract and gave them the bibliography that  
02:45 24 was footnoted in the text.

02:45 25 Q. And you would do the same thing in authoring an expert

02:45 1 report, correct, you would try to convey, in fact, you do, you  
02:45 2 say, records reviewed, in the first paragraph of your first  
02:45 3 report, you list them up; correct?

02:46 4 A. I list the records reviewed, in order to state what I had  
02:46 5 available, yes. I did not detail each and every record  
02:46 6 reviewed, because that would make the report both unreadable  
02:46 7 and 100 pages.

02:46 8 Q. Doctor, you listed some medical records. You listed that  
02:46 9 you reviewed the coroner's report, autopsy and toxicology  
02:46 10 report, medical records from the coroner, medical records from  
02:46 11 Dr. Evers' office. Did I read that correctly?

02:46 12 A. Yes.

02:46 13 Q. You have the medical records from Dr. Evers's office, for  
02:46 14 some reason, these are in the reverse order. March 6 of 2013 to  
02:46 15 September 9 of 2014; correct?

02:46 16 A. That is correct.

02:46 17 Q. So you did, in that specific instance, list out exactly  
02:46 18 what you reviewed; correct?

02:46 19 A. Right, but, for example, I grouped medical records from  
02:47 20 Dr. Evers' office in a date range, but yes, that's what I  
02:47 21 reviewed.

02:47 22 Q. You, actually, gave us the dates of those office visits;  
02:47 23 correct?

02:47 24 A. Yes. The inclusive range not the interval range.

02:47 25 Q. Understood. Doctor, when you treated patients in your

02:47 1 clinical practice, when you had an active clinical practice,  
02:47 2 prior to 2014, and you prescribed for them pain medication in a  
02:47 3 variety of scenarios, I believe you talked about palliative  
02:47 4 pain and cancer pain and chronic pain and acute pain and nerve  
02:47 5 pain and somatic pain, all of those scenarios, when you did  
02:47 6 that, all of your patients -- and this is going to sound like a  
02:47 7 stupid question -- all of those patients were alive; correct?

02:47 8 A. Until some of them died, yes.

02:48 9 Q. Right, and you said, in fact, you made a joke about it,  
02:48 10 you were able to dangle them over the grave and pull them back;  
02:48 11 correct?

02:48 12 A. There, I'm referring, specifically, to general anesthesia.

02:48 13 Q. Specifically, to general anesthesia, in the OR, when you  
02:48 14 put somebody under; correct?

02:48 15 A. Yes, which represents part of my clinical experience with  
02:48 16 drug overdose.

02:48 17 Q. When you talk about treating patients like that, I mean,  
02:48 18 the point is, you bring them back and they're alive; correct?  
02:48 19 What I'm getting at is that, in your active clinical practice  
02:48 20 of medicine, it wasn't a normal part of your routine -- or  
02:48 21 maybe you can correct me -- that you would deal with patients  
02:48 22 who had passed away?

02:48 23 A. No, but in the course of providing anesthetics, I had  
02:48 24 three intraoperative deaths.

02:48 25 Q. I'm sorry to hear that. I'm not getting at that, but I'm

02:48 1 getting at the point is, Doctor, you answered earlier that you  
02:48 2 don't do autopsies, you're not a pathologist?

02:49 3 A. That's correct.

02:49 4 Q. When you see patients, they're alive; correct?

02:49 5 A. Correct.

02:49 6 Q. I'm sorry, that's the way I should have asked it in the  
02:49 7 first place. And when they're alive, they're metabolizing that  
02:49 8 medication that you gave them oftentimes; correct?

02:49 9 A. That is correct.

02:49 10 Q. And when they're dead, there's a different process going  
02:49 11 on; correct?

02:49 12 A. Yes, there are a number of things that occur, at the time  
02:49 13 of death, that change the distribution of the compartments.

02:49 14 Q. Right, and it changes the distribution of the drugs that  
02:49 15 are found on blood tests; correct?

02:49 16 A. That is correct.

02:49 17 Q. Time affects that, as well; correct?

02:49 18 A. That is correct.

02:49 19 Q. And the puncture point, where the blood is drawn from,  
02:49 20 whether it's drawn from the superior vena cava or whether it's  
02:49 21 drawn from the femoral source or whether it's drawn from a  
02:49 22 popliteal source would have effect on what those values are;  
02:49 23 correct?

02:49 24 A. It would have an effect upon the point estimate, yes.

02:49 25 Q. So it would be important to you, Doctor, as an

02:49 1 anesthesiologist or a pain medicine doctor who is reviewing a  
02:49 2 postmortem to know the point that the pathologist drew the  
02:50 3 blood from, correct, the anatomical point?

02:50 4 A. Not exactly, no. While it could make a difference, in  
02:50 5 terms of the point estimate, the issue of the number, that is,  
02:50 6 whether or not we're using the toxicology, because, as I  
02:50 7 pointed out, we don't use a toxicology as a separate  
02:50 8 determinant, we use it as part of the overall determination.

02:50 9 So the number, simply, in fact, given the clinical  
02:50 10 setting, need only be in the range of reported numbers for that  
02:50 11 particular drug, in order for it to be, more likely than not,  
02:50 12 that it is producing the effects that are seen, particularly,  
02:50 13 when we are doing that in the setting of a mixed drug  
02:50 14 intoxication like that of nordiazepam and Methadone.

02:51 15 Q. Now, I'm not sure I understood all of that, Doctor. My  
02:51 16 question is, simply, would it make a difference in the value  
02:51 17 that's returned, for the blood value of the drug you're looking  
02:51 18 at, in this case, Methadone, depending on the source of the  
02:51 19 blood draw anatomically; correct?

02:51 20 A. The blood draw, if we were to draw them separately or  
02:51 21 simultaneously from different sites may be different. However,  
02:51 22 for the purpose for which that number is being used, in terms  
02:51 23 of determining whether or not the patient had a toxic quantity  
02:51 24 of the drug in their blood, at the time death, that particular  
02:51 25 point estimate is precisely that.

02:51 1 Do I believe that at every point in her body, at the time  
02:51 2 of death, that Kristina Dame had a Methadone concentration of  
02:51 3 180 nanograms per milliliter? No. I'm sure that it was  
02:51 4 different at different points.

02:51 5 Do I believe that that particular number, 180 nanograms  
02:52 6 per milliliter, was the same at the moment that she ceased to  
02:52 7 respire, as it was at the time that the blood was drawn? No.  
02:52 8 Because that's not the way it works, because there are things  
02:52 9 that cause flux in the concentration.

02:52 10 But the real issue is, given that the reported  
02:52 11 concentrations in patients who have died from single-drug  
02:52 12 intoxication with Methadone is between 60 and 300 -- I'm  
02:52 13 sorry -- 3100, she is within the range. She, additionally, has  
02:52 14 the presence of nordiazepam. She, additionally, has no other  
02:52 15 indication of any other lethal event. She has that occurring in  
02:52 16 the setting of a patient who has her history and the  
02:52 17 prescribing that has occurred.

02:52 18 That is the manner by which I determined the but-for  
02:52 19 cause, not by, simply, the single number of 180 nanograms per  
02:53 20 milliliter.

02:53 21 Q. Can you give us that reference range again for what could  
02:53 22 be toxic with Methadone?

02:53 23 A. It has been reported between 60 nanograms per mill and  
02:53 24 3100.

02:53 25 Q. And that depends, in part, on the drug tolerance of the

02:53 1 patient; correct?

02:53 2 A. It depends upon the clinical setting.

02:53 3 Q. You would agree with me, Doctor, that if the -- why don't  
02:53 4 you explain to the Court, Doctor, if you can, what autolysis  
02:53 5 is.

02:53 6 A. Autolysis is the process by which cells break down through  
02:53 7 enzymatic processes and release their contents into their  
02:53 8 environment which equivalates with the blood compartment.

02:53 9 Q. So the blood is drawn after the patient has been dead for  
02:53 10 God knows how many hours in this case, if the blood is drawn  
02:53 11 from the superior vena cava, that could have -- return a higher  
02:53 12 value, due to autolysis, than if it was drawn peripherally;  
02:54 13 correct? Or should I defer to Dr. Ross?

02:54 14 A. There can be a higher level, from various aspects,  
02:54 15 however, for the purpose of the determination of whether or not  
02:54 16 she died from mixed drug intoxication, of which Methadone was a  
02:54 17 substantive part, it makes no difference.

02:54 18 Q. Doctor, you would agree with me that patients who have a  
02:54 19 blood value of 180 nanograms per milliliter can go about their  
02:54 20 daily functions at that level, can't they, depending upon their  
02:54 21 tolerance to the drug?

02:54 22 A. Yes, and, in fact, that value can be seen as a therapeutic  
02:54 23 value in patients who have been gradually raised to it, but it  
02:54 24 is certainly a toxic value in patients who have been rapidly  
02:55 25 raised to it.

02:55 1 Q. A very low value could be a toxic value to me, if I'm a  
02:55 2 first-time user; correct?

02:55 3 A. I didn't hear the last part.

02:55 4 Q. A very low amount of Methadone could be toxic to anyone  
02:55 5 who is a first-time user who is completely naive to the drug;  
02:55 6 correct?

02:55 7 A. Right.

02:55 8 Q. But if someone is tolerant to the drug and they've been  
02:55 9 having the drug over some time, in this case -- strike that. If  
02:55 10 they've been having the drug over some time, they can develop a  
02:55 11 tolerance to it, so they can have higher blood values of  
02:55 12 Methadone and yet still function; correct?

02:55 13 A. Yes, and importantly, that does not apply to her.

02:55 14 Q. I'm sure you've seen that in your practice, Doctor, isn't  
02:55 15 that true? You've seen people with higher Methadone levels go  
02:55 16 about their daily function?

02:55 17 A. If the amount is raised gradually, that can occur.  
02:55 18 However, deaths have been known to occur at relatively low  
02:55 19 doses of Methadone, between 30 and 40 milligrams per day. In  
02:55 20 fact, in Methadone maintenance institutions, the most common  
02:55 21 time during which that overdose death will occur is at about 50  
02:56 22 milligrams per day.

02:56 23 So it depends upon the direction and the magnitude of the  
02:56 24 change. That vector is very important in making that  
02:56 25 determination.

02:56 1 Q. And it's very broad?

02:56 2 A. Yes, and, therefore, must be interpreted in terms of the  
02:56 3 clinical history of the individual patient.

02:56 4 Q. Doctor, have you supplied us with any citations in your  
02:56 5 report that would support what you're saying about that 180  
02:56 6 nanograms per milligram being a fatal dose?

02:56 7 Do you have any peer-reviewed documents, peer-reviewed  
02:56 8 studies, evidence-based studies anywhere cited in your report  
02:56 9 that would support that assertion?

02:56 10 A. I did not cite it in my report.

02:56 11 Q. Well, the answer is, no, then, correct, Doctor?

02:56 12 A. I did not cite it in my report.

02:57 13 Q. Yet, you knew the purpose of this report was to inform us  
02:57 14 and to inform the Court what you were doing here, correct, and  
02:57 15 you failed to cite the specific -- you say you have one -- the  
02:57 16 specific peer-reviewed, evidence-based study that's going to  
02:57 17 tell us that if Dr. Evers gives a patient 180 milligrams, what  
02:57 18 amounts to 180 nanograms per milligram of Methadone, that  
02:57 19 patient is going to die?

02:57 20 A. Not that the patient is going to die, but the patient is  
02:57 21 at risk for death, and it's in her medical record, it's in her  
02:57 22 autopsy in the Toxicology section.

02:58 23 Q. While we're talking about toxicology, Doctor, it just  
02:58 24 gives a value not a range to give the 180 nanograms, as you  
02:58 25 said, per millimeter; correct?

02:58 1 A. It does give a range for the values which have been  
02:58 2 observed at death.

02:58 3 Q. So that's 60 to 3100; correct?

02:58 4 A. Yes.

02:58 5 Q. Blood Methadone concentrations average 280 nanograms per  
02:58 6 milliliter in 59 victims of fatal Methadone overdose.

02:58 7 A. Average is a central tendency.

02:58 8 Q. So average is 260 nanograms per milliliter; correct?  
02:58 9 That's in the toxicology report.

02:58 10 A. Yes, and that's also single drug, not mixed. Continue.  
02:59 11 Thank you.

02:59 12 Q. Doctor, you'd also notice that, on her urine screen, there  
02:59 13 was fentanyl; correct?

02:59 14 A. Yes.

02:59 15 Q. When you talked to Dr. Coyer who is the toxicologist who  
02:59 16 actually did this study, and you talked to him on the telephone  
02:59 17 and asked him about the study -- and, Doctor, this should be in  
02:59 18 front of you. Do you have the toxicology report and postmortem?

02:59 19 A. I do not.

02:59 20 Q. There should be a binder up there, Doctor. It's Page 0057.

02:59 21 A. There is no binder here. Okay, yes.

03:00 22 Q. Doctor, are you there on the toxicology report dated  
03:00 23 12/8/14 signed by Dr. Coyer?

03:00 24 A. 12/25/14.

03:00 25 Q. 9/25/14.

03:00 1 A. I'm sorry, 9/25/14.

03:00 2 Q. That's correct. The signature date at the bottom, Doctor,  
03:00 3 is 12/8/14.

03:00 4 A. Okay, yes.

03:01 5 Q. On Page 4 of your report, Doctor, you state -- I'll read  
03:01 6 it to you if you have a copy there.

03:01 7 A. I have it.

03:01 8 Q. "While the toxicology report stated that multiple over 400  
03:01 9 drugs were screened, the precise findings were not clear.

03:01 10 Given the absence of a list of negative findings, I contacted  
03:01 11 the testing laboratory for procedural verification."

03:01 12 Did I read that correctly?

03:01 13 A. Yes.

03:01 14 Q. I think, when we're talking about this, there is the  
03:01 15 footnote at bottom of Dr. Coyer's toxicology report, where it  
03:01 16 says, "The resulting data", and on the third line down, "is  
03:01 17 compared to an extensive spectral library of over 400 of the  
03:01 18 most commonly found illicit and prescription drugs."

03:01 19 Did I read that correctly?

03:01 20 A. That's correct.

03:01 21 Q. So what did Dr. Coyer tell you that meant?

03:01 22 A. That all the things that were not reported were negative.

03:02 23 Q. I'm sorry, say that again.

03:02 24 A. Everything that was not reported as positive was negative.

03:02 25 Q. But only as opposed to what's been tested against that

03:02 1 library of 400 chemicals; correct?

03:02 2 A. Yes.

03:02 3 Q. So did Dr. Coyer tell you, for example, that if there was  
03:02 4 fentanyl in her system that was not in that spectral library,  
03:02 5 it wouldn't show up on that test; correct?

03:02 6 A. That was -- that's a common drug of abuse that would have  
03:02 7 been tested, which was why it was tested in her urine.

03:02 8 Q. It showed up in her urine from the fentanyl from the  
03:02 9 patch; correct?

03:02 10 A. Presumably.

03:02 11 Q. There was no patch on her body, according to the  
03:02 12 postmortem; correct?

03:02 13 A. Some.

03:02 14 Q. But she had -- she didn't have a patch on her body, but  
03:02 15 she had fentanyl in her urine; correct?

03:02 16 A. I would have to look at the --

03:02 17 THE COURT: Just a moment, sir.

03:03 18 MS. OLSHEFSKI: I'm going to object, at this point, only  
03:03 19 because this is a Daubert hearing, and we're supposed to be  
03:03 20 challenging the qualifications, the methodology, the  
03:03 21 reliability, and the fit of expert testimony in this case. This  
03:03 22 is not the trial, and to attack the substance and the  
03:03 23 credibility of opinions in this way is not appropriate for a  
03:03 24 Daubert hearing.

03:03 25 MR. BRIER: Your Honor, under Rule 702, I'm allowed to

03:03 1 check his methodology and the foundations for the information  
03:03 2 that he provided. And he's authored two expert reports, the  
03:03 3 Government went through the basis and foundation, as they saw  
03:03 4 it, and I'm allowed to challenge it. Specifically, under 702,  
03:03 5 Your Honor, I'm allowed to challenge the quality -- I'm sorry  
03:03 6 -- the expert's scientific, technical and other specialized  
03:03 7 knowledge that will help the trier of fact understand the  
03:03 8 evidence, including the information that is the reliable  
03:04 9 foundation, whether there's a reliable foundation for the  
03:04 10 report.

03:04 11 So my question gets to, Doctor --

03:04 12 THE COURT: Just a moment. I didn't rule on anything.

03:04 13 MR. BRIER: I'm sorry, Your Honor, I meant to say -- my  
03:04 14 question was to Your Honor, and I said, Doctor, out of force of  
03:04 15 habit.

03:04 16 THE COURT: I'm going to give you some leeway, but Ms.  
03:04 17 Olshefski is correct, you're not trying this case to me.  
03:04 18 Surely, you all understand that.

03:04 19 MR. BRIER: Understood, Your Honor.

03:04 20 THE COURT: You can certainly inquire into his methodology,  
03:04 21 and you can certainly inquire into what facts were in his  
03:04 22 possession upon which he based his opinion or opinions, but I  
03:04 23 am not going to allow this to be turned into a mini-trial on  
03:04 24 his ultimate believability before the jury.

03:04 25 So be guided by that. And if you think that's happening,

03:04 1 Ms. Olsheski, you object. Let's go.

03:05 2 MR. BRIER: Thank you, Your Honor.

03:05 3 BY MR. BRIER:

03:05 4 Q. Doctor, in the report that you authored, you indicated  
03:05 5 that -- I'll move on, Your Honor.

03:05 6 You indicated that, on the second page, Doctor, first full  
03:05 7 paragraph, it says;

03:05 8 "The earliest documentation that I have available,  
03:05 9 regarding Dr. Martin Evers, an internist, care of Ms. Dame was  
03:05 10 dated March 20, 2013." Did I read that correctly?

03:05 11 A. Yes.

03:05 12 Q. Doctor, are you aware of any documentation of office  
03:05 13 visits prior to March 20 of 2013?

03:06 14 A. That was the first office note. There were papers in her  
03:06 15 file as early as March 6, 2013.

03:06 16 Q. So that was the first office visit she had with Dr. Evers,  
03:06 17 according to your review of the records, Doctor, was March 20,  
03:06 18 2013; correct?

03:06 19 A. Yes, there were some other contact with his office as  
03:06 20 early as March 6, 2013.

03:06 21 Q. And, then, Doctor, a year later, in September 2020, you  
03:06 22 authored a supplemental report, and you indicated that you had  
03:06 23 reviewed additional documentation; correct?

03:06 24 A. Yes.

03:06 25 Q. Doctor, turn to the binder in front of you, if you would,

03:07 1 to Page 64568.

03:07 2 A. Yes.

03:07 3 Q. Do you want to identify that for the record, please?

03:07 4 A. This appears to be an office note from Dr. -- it's an  
03:07 5 office note, I don't know who it's from, because there is no  
03:08 6 signature, but it's dated 10/11/2012, and it says she comes in  
03:08 7 to establish care.

03:08 8 Q. That says, "Kristina came in to establish care. Her  
03:08 9 medical issues include chronic back pain." Correct?

03:08 10 A. Yes. Did you want me to read it?

03:08 11 Q. No, I'm going to ask you, did Dr. Evers take a subjective  
03:08 12 history from the patient?

03:08 13 A. Did Dr. Evers do this? I don't see his signature.

03:08 14 Q. I can get you a page that has the signature line on it.

03:08 15 A. Okay.

03:08 16 Q. 64506.

03:09 17 A. Okay, yes, this appears to be from Dr. Evers, yes.

03:09 18 Q. Office note from Dr. Evers for Kristina Dame; correct?

03:09 19 A. Yes.

03:09 20 Q. You were not provided that for your initial review;  
03:09 21 correct?

03:09 22 A. No, I've never seen it before.

03:09 23 Q. Did Dr. Evers do an assessment of the patient?

03:10 24 A. There is a brief assessment, yes.

03:10 25 Q. Did he review old hospital available data, going back to

03:10 1 2012, including imaging and labs?

03:10 2 A. Actually, it appears that he reviewed hospitalizations  
03:10 3 going back to 2009 for detoxification from opioids and  
03:10 4 benzodiazepines and labs, yes.

03:10 5 Q. Doctor, turn the page to 64567. Can you identify that for  
03:10 6 the record, please?

03:10 7 A. This is an office note from Dr. Evers, date of service  
03:11 8 November 8, 2012.

03:11 9 Q. Was that provided to you by the Government for your  
03:11 10 review?

03:11 11 A. No, I have not seen this before.

03:11 12 Q. That's a SOAP note, correct, that's what doctors call  
03:11 13 them, Subjective Objective Assessment and Plan; correct?

03:11 14 A. Yes.

03:11 15 Q. He takes her vital signs, notes her medications; correct?

03:11 16 A. Yes.

03:11 17 Q. You'll note she was on Morphine and Valium, at that time;  
03:11 18 correct?

03:11 19 A. Yes.

03:11 20 Q. She was also receiving MS Contin and Lyrica and Santyl,  
03:11 21 which is a topical cream for a skin lesion; correct?

03:11 22 A. MS Contin is Morphine, and Morphine, Lyrica, Valium.

03:11 23 Q. I'm sorry, the Morphine is listed there, correct, I read  
03:11 24 that.

03:11 25 A. Yes, and MS Contin is Morphine, so she was receiving high

03:11 1 dose Morphine --

03:12 2 Q. And Valium and Lyrica?

03:12 3 A. Valium and Lyrica, yes.

03:12 4 Q. Doctor, turn the page to 64566. Can you identify that for  
03:12 5 the record?

03:12 6 A. This is an office note from 12/4/2012.

03:12 7 Q. Was that provided to you by the Government for your expert  
03:12 8 review?

03:12 9 A. I have not seen this before.

03:12 10 Q. That's a SOAP note for Kristina Dame in Dr. Evers' office;  
03:12 11 correct?

03:12 12 A. Yes.

03:12 13 Q. Doctor, turn the page. 64565. Identify that for the  
03:12 14 record, please.

03:12 15 A. It's another progress note from 24 days later.

03:12 16 Q. That's a SOAP note; correct?

03:12 17 A. Yes.

03:12 18 Q. Six lines down in the first paragraph, you can read along  
03:13 19 with me;

03:13 20 "Pain medication is now adequate, but she is not sleeping  
03:13 21 well."

03:13 22 Is that an assessment of the effectiveness of the pain  
03:13 23 medication she was receiving at that point?

03:13 24 A. Yes.

03:13 25 Q. Doctor, turn the page to 64564. Could you identify that

03:13 1 for the record, please?

03:13 2 A. Another progress note from date of service January 15,  
03:13 3 2013.

03:13 4 Q. And that's for Kristina Dame from Dr. Evers?

03:13 5 A. That is correct.

03:13 6 Q. Was that provided to you by the Government for your expert  
03:13 7 review?

03:13 8 A. I have not seen it before.

03:13 9 Q. It documents that she was in the Emergency Department;  
03:13 10 correct?

03:13 11 A. I didn't understand the question.

03:13 12 Q. I'm sorry. Third paragraph down, Doctor. It documents that  
03:13 13 Dr. Evers said she was in the Emergency Department because of  
03:14 14 excessive urination and inconsistent urination; correct?

03:14 15 A. Yes.

03:14 16 Q. And he notes there what her labs are; correct?

03:14 17 A. Yes.

03:14 18 Q. Doctor, turn the page to 64563. Can you identify it for  
03:14 19 the record, please?

03:14 20 A. January 22, 2013. It is a progress note that details that,  
03:14 21 "Her pain medications are allegedly adequate. She's on high  
03:14 22 dose oxycodone, Valium, Lyrica, Santyl and trazodone. She has  
03:14 23 had two falls injuring her left ankle."

03:14 24 Q. That's a SOAP note for Kristina Dame in Dr. Evers' office  
03:14 25 one week after the last visit; correct?

03:15 1 A. That is correct.

03:15 2 Q. Was that provided to you by the Government?

03:15 3 A. I have not seen it before. As I stated, the first progress  
03:15 4 note I had was 3/20.

03:15 5 Q. Doctor, turn the page. Page 64562.

03:15 6 A. Yes, another progress note dated February 19, 2013.

03:15 7 Q. So this is three weeks later, she's in his office again;  
03:15 8 correct?

03:15 9 A. Yes.

03:15 10 Q. She has a psoriatic lesion and he orders Prednisone, a  
03:15 11 steroid; correct?

03:15 12 A. That is correct.

03:15 13 Q. He palpates her abdomen for tenderness and he notes she  
03:15 14 has a lesion along her C-section scar on her abdomen; correct?

03:15 15 A. That is correct.

03:15 16 Q. Did you have that note, Doctor, before you opined your  
03:15 17 expert opinion about Dr. Evers' treatment of Kristina Dame?

03:15 18 A. I did not.

03:16 19 Q. Going back to the first note of October 11, 2012, it notes  
03:16 20 in there at the bottom, Doctor, last paragraph. It says;

03:16 21 "She has an MRI that shows she has a cyst, a syrinx."

03:16 22 Could you explain what a syrinx is?

03:16 23 A. A syrinx is a collection of cerebral spinal fluid that  
03:16 24 occurs in the central canal of the spinal cord. Cerebral spinal  
03:16 25 fluid bathes the spinal cord and is generated inside the

03:17 1 ventricles or spaces of the brain. The central canal of the  
03:17 2 spinal cord is normally very small. If there's a blockage to  
03:17 3 the outflow of cerebral spinal fluid which flows through it and  
03:17 4 through areas that dump the cerebral spinal fluid into the  
03:17 5 veins, the pressure builds up, and you get a collection of  
03:17 6 spinal fluid called a syrinx that compresses the nerves  
03:17 7 surrounding it.

03:17 8 Q. And that's an objective imaging finding that would support  
03:17 9 that she has a lesion in her spinal cord, correct, or, at  
03:17 10 least, adjacent to her spinal cord?

03:17 11 A. Yes, I noted that she had a diagnosis of syringomyelia.

03:17 12 Q. Doctor, if you go back up to the first paragraph under,  
03:17 13 Available Old Data, last paragraph -- I'm sorry, last sentence.  
03:17 14 It says;

03:17 15 "Urine drug screen with benzodiazepines, opioids,  
03:17 16 tricyclics, pregnancy test negative."

03:18 17 You'd agree with me, Doctor, that's documentation in  
03:18 18 Dr. Evers' chart of a urinalysis report?

03:18 19 A. That is a documentation that someone else did a urine drug  
03:18 20 screen, yes.

03:18 21 Q. Yes, and he put that in his review, in the first visit the  
03:18 22 patient was in his office; correct?

03:18 23 A. That is correct. In fact, that was noted in my report that  
03:18 24 other physicians have performed urine drug screens.

03:19 25 Q. Doctor, you had testified earlier about the Morphine

03:19 1 equivalency of Methadone; correct?

03:19 2 A. I did.

03:19 3 Q. And you gave us the chart that was in the CDC Guidelines;  
03:19 4 correct?

03:19 5 A. Yes.

03:19 6 Q. I believe that the Government moved that exhibit into  
03:19 7 evidence.

03:19 8 Methadone -- on Government Exhibit 9, Page 2 -- they give  
03:19 9 a range from 1 to 80 milligrams a day for their Morphine  
03:19 10 equivalency conversion factors; correct?

03:19 11 A. That's from 1 to 80 milligrams of Morphine equivalence per  
03:19 12 day at 1 to 20 milligrams of Methadone.

03:19 13 Q. Right below that, it says;

03:20 14 "Dose conversions are estimates and cannot account for all  
03:20 15 individual differences in genetics and pharmacokinetics."

03:20 16 Correct?

03:20 17 A. Absolutely.

03:20 18 Q. Doctor, do you recall testifying in the Dr. Li case?

03:20 19 A. Dr. who?

03:20 20 Q. Dr. Li.

03:20 21 A. Yes.

03:20 22 Q. You testified the way you're testifying today, you were  
03:20 23 under oath and in the courtroom; correct?

03:20 24 A. Yes.

03:20 25 Q. In fact, I believe it was Judge Mariani; correct?

03:20 1 A. No, it was not, it was Judge Caputo.

03:20 2 Q. My mistake. In that case -- and I could show you if you  
03:20 3 want to see it -- you said the Methadone multiplier for a  
03:20 4 conversion is 4.5.

03:20 5 A. Yes.

03:20 6 Q. And that it builds up in the body. Do you stand by that?

03:20 7 A. At lower doses, that's the straight line conversion. It  
03:21 8 does not take into account higher doses of Methadone, that's  
03:21 9 correct.

03:21 10 Q. And it doesn't take into account the variability with  
03:21 11 different patients; correct?

03:21 12 A. It does not, it is an estimate.

03:21 13 Q. Doctor, your initial report dated August of 2019, you had  
03:22 14 testified -- I'm sorry -- you wrote that Ms. Dame was opioid  
03:22 15 naive; correct?

03:22 16 A. That is correct.

03:22 17 Q. And then, after reviewing more of her records, you amended  
03:22 18 that to say she was relatively opioid naive; correct?

03:22 19 A. That's true.

03:22 20 Q. Could you explain to me, Doctor, where you got the term,  
03:22 21 relatively opioid naive?

03:22 22 A. From English. Ms. Dame had been opioid tolerant during the  
03:22 23 period of continuous prescription of Methadone, as much as 160  
03:22 24 milligrams per day, from Dr. Evers. After Ms. Dame left  
03:22 25 Dr. Evers' care in early July of 2014 and went to First

03:23 1 Hospital, she was weaned from the -- from Methadone, initially,  
03:23 2 and in that time, from July 1 through January -- I'm  
03:23 3 sorry -- September 3, she obtained three prescriptions from  
03:23 4 physicians who were not Dr. Evers. One for 84 tablets, one for  
03:23 5 36 tablets, and the last for seven tablets.

03:23 6 The prescription she obtained for seven tablets was  
03:23 7 written on -- one moment please -- was written a week prior to  
03:24 8 the prescription she got from Dr. Evers, and, in fact, she was  
03:24 9 administered five milligrams of Methadone at Horsham Clinic as  
03:24 10 her last dose prior to the prescription that she got from  
03:24 11 Dr. Evers, and that was, at least, four days prior to his  
03:24 12 seeing her.

03:24 13 That means that she had been without Methadone for four  
03:24 14 days, after having been weaned from 150 milligrams down to 5  
03:24 15 milligrams. If we take into account that last seven tablet, 70  
03:25 16 milligrams, over the course of the last 10 days, then, she  
03:25 17 would have been getting, roughly, in the last week, about 8  
03:25 18 milligrams of Methadone per day, if we average it over that  
03:25 19 period, not including any periods of complete abstinence.

03:25 20 Relative to her Methadone tolerance at 160 milligrams, she  
03:25 21 was relatively opioid naive. She had been weaned over a  
03:25 22 prolonged period, and one would expect that, physiologically,  
03:25 23 her opioid tolerance would be quite low. That's what I mean by  
03:25 24 relatively.

03:25 25 Q. Well, isn't the half life of Methadone variable, as well,

03:25 1 in terms of with the conversion on the Morphine units is  
03:25 2 variable, depending on the patient?

03:25 3 A. It is.

03:25 4 Q. So what you said, her last dose of Methadone was just four  
03:26 5 days before --

03:26 6 MS. OLSHEFSKI: Objection, Your Honor. I think we're  
03:26 7 getting into an area of testing the credibility of Dr. Thomas'  
03:26 8 opinions.

03:26 9 THE COURT: Sustained.

03:26 10 BY MR. BRIER:

03:26 11 Q. Doctor, it would be important to your analysis when her  
03:26 12 last dose of opioids was; correct?

03:26 13 A. It would be -- I'm not sure I would say it was important,  
03:26 14 it is a particular data point. I think, because we are talking  
03:26 15 about orders of magnitude, the precise moment of her last dose  
03:26 16 is not.

03:26 17 Q. Do you have any peer-reviewed or any evidence-based  
03:26 18 documentation that you can cite to that tells us, specifically,  
03:26 19 what the half life is of Methadone in these circumstances?

03:27 20 A. In Ms. Dame?

03:27 21 Q. Yes.

03:27 22 A. The half life of Methadone is always referred to in a  
03:27 23 range, with the longest half life being, that's reported in the  
03:27 24 literature, being about 56 hours, with the shortest half life  
03:27 25 in some patients who are so-called rapid accelerators being as

03:27 1 short as eight hours. Beyond that, I do not know. The general  
03:27 2 observable half life in most patients tends to be in the range  
03:27 3 of 24 hours.

03:27 4 However, because we are talking about orders of magnitude  
03:27 5 difference in dosing, that is not an appreciably important  
03:27 6 fact, in terms of my overall analysis.

03:27 7 Q. Doctor, when you reviewed the Pennsylvania State Police  
03:27 8 report to form your opinion, when you reviewed the coroner's  
03:27 9 report to form your opinion, when you reviewed Dr. Evers'  
03:28 10 records, you reviewed the photographs we heard about on direct  
03:28 11 examination, where did you learn, Doctor, that the Methadone  
03:28 12 that was in Kristina Dame's system, on autopsy, was the  
03:28 13 Methadone that came from Dr. Evers?

03:28 14 A. From the prescribing.

03:28 15 Q. There was a prescription bottle in the photograph;  
03:28 16 correct?

03:28 17 A. I believe so, yes.

03:28 18 Q. How many pills were out of it?

03:28 19 A. I can't tell you.

03:28 20 Q. Can you tell me whether it was relatively full?

03:28 21 A. At this moment, I cannot tell you.

03:28 22 Q. Did you see any Pennsylvania State Police inventory where  
03:28 23 a pill count was done on the bottle that was found with  
03:28 24 Kristina Dame?

03:28 25 A. It's 8,000 pages. I think that there was, but I cannot

03:29 1 tell you that for a fact at this very moment.

03:29 2 Q. You think there was a pill count, but you don't recall?

03:29 3 MS. OLSHEFSKI: Objection, Your Honor.

03:29 4 THE WITNESS: I'm unsure.

03:29 5 THE COURT: Just a moment. When an objection is raised,  
03:29 6 stop, please.

03:29 7 THE WITNESS: I'm sorry, sir.

03:29 8 MS. OLSHEFSKI: Same reason, Your Honor. He's attacking the  
03:29 9 credibility of Dr. Thomas, and that's not the purpose of this  
03:29 10 hearing. I'm sorry, he's attacking the credibility of the  
03:29 11 opinion of Dr. Thomas.

03:29 12 THE COURT: Sustained.

03:29 13 BY MR. BRIER:

03:29 14 Q. Doctor, you testified at length, on direct examination,  
03:29 15 about the but-for causation of the death of Kristina Dame;  
03:29 16 correct?

03:29 17 A. That is correct.

03:29 18 Q. In there, I'm asking you, simply, where did you put  
03:29 19 together the prescription from Dr. Evers with the Methadone  
03:29 20 that was in her system on the postmortem? Did you infer it?

03:30 21 A. Given the pattern of prescribing and the way in which Ms.  
03:30 22 Dame used it, yes, I inferred it, particularly, given that the  
03:30 23 last administered Methadone was from Horsham Clinic.

03:30 24 MR. BRIER: That's all I have, Your Honor.

03:30 25 THE COURT: Do you have redirect, Ms. Olshefski?

03:30 1 MS. OLSHEFSKI: Just a few questions, Your Honor.

03:30 2 REDIRECT EXAMINATION

03:30 3 BY MS. OLSHEFSKI:

03:30 4 Q. Dr. Thomas, based upon the assessment notes that the  
03:30 5 Defense went over with you, June, October, November of '12,  
03:30 6 prior to March of '13, does that, in any way, change your  
03:30 7 opinion?

03:30 8 A. No, because, while I had problems with the overall dosing  
03:30 9 and the approach, those were not the time -- that was not the  
03:30 10 time frame during which I found the prescribing not for a  
03:30 11 medically legitimate purpose in the usual course of  
03:30 12 professional practice. It's the end of the time frame, not the  
03:30 13 beginning.

03:30 14 Q. Okay. And, specifically, directing your attention to Page  
03:31 15 64506, which was addressed by Defense counsel, under Available  
03:31 16 Old Data. Do you see that?

03:31 17 A. Yes.

03:31 18 Q. Is it correct that --

03:31 19 MR. BRIER: Your Honor, I object. This witness has already  
03:31 20 admitted, under oath, that these were not part of his expert  
03:31 21 reports and not part of his review. So why we're going through  
03:31 22 them, now, is, I think, the Government's attempt to bolster his  
03:31 23 credibility, when it's exactly what her objection was a minute  
03:31 24 ago.

03:31 25 MS. OLSHEFSKI: Your Honor, he's the one that brought this

03:31 1 up and directed Dr. Thomas' attention to it, and conveniently  
03:31 2 skipped over significant parts, leaving an impression that  
03:31 3 needs to be addressed here.

03:31 4 MR. BRIER: Your Honor, I addressed what was skipped over  
03:31 5 pretty well, I believe.

03:31 6 THE COURT: You can address your questions to what you  
03:31 7 thought was skipped over and then move on, because everybody is  
03:31 8 moving past the target of a Daubert hearing, and I'm not going  
03:32 9 to allow it. Go ahead.

03:32 10 MS. OLSHEFSKI: Just two points, Your Honor.

03:32 11 BY MS. OLSHEFSKI:

03:32 12 Q. Dr. Thomas, do you see, under Available Old Data, June 20,  
03:32 13 2012?

03:32 14 A. Yes.

03:32 15 Q. It reads, "Hospitalization because of drug withdrawal."

03:32 16 A. Yes.

03:32 17 Q. And based upon what you're seeing there, does that change  
03:32 18 your opinion, at all?

03:32 19 A. No, because, in fact, the Available Old Data section was  
03:32 20 present in other notes that I did review, because the  
03:32 21 computerized medical record repeats it over and over, so I was  
03:32 22 aware that Dr. Evers was aware of her hospitalizations for drug  
03:32 23 withdrawal and her hospitalizations for fractures after fall  
03:32 24 and her hospitalizations for detoxification from opioids and  
03:32 25 benzodiazepines.

03:32 1 Q. Then, right down from there, September 2, 2009, a few  
03:32 2 years prior.

03:32 3 "Hospitalization for detoxification from opiates and  
03:33 4 benzodiazepine."

03:33 5 Did you come across that in your historical review of  
03:33 6 Kristina Dame?

03:33 7 A. Yes.

03:33 8 Q. Did it contribute to your opinion in this case?

03:33 9 A. Yes.

03:33 10 MS. OLSHEFSKI: Thank you. Nothing further, Judge.

03:33 11 THE COURT: Mr. Brier?

03:33 12 MR. BRIER: Nothing further, Your Honor.

03:33 13 THE COURT: Thank you, Dr. Thomas. You can step down.

03:33 14 THE WITNESS: Thank you, Your Honor.

03:33 15 THE COURT: Ms. Olshefski, does the Government propose to  
03:33 16 offer any additional witnesses in this matter?

03:33 17 MS. OLSHEFSKI: Not for the Daubert hearing, Your Honor.

03:33 18 THE COURT: I take it, Mr. Brier, that you have no  
03:33 19 witnesses in connection with the Daubert hearing?

03:33 20 MR. BRIER: Correct, Your Honor.

03:33 21 THE COURT: All right, now, we're going to try to move from  
03:33 22 the Daubert issue, unless there's some reason either counsel  
03:33 23 wants to further address it, which I'm not hearing, we will  
03:33 24 move to the Motion to Suppress, with respect to Bennett Avenue.

03:33 25 There was some logistical issue we needed to talk about

03:34 1 that I deferred until the Daubert hearing was over. This might  
03:34 2 be an appropriate time to hear both counsel as to what the  
03:34 3 issue is and what your positions are on it.

03:34 4 MS. OLSHEFSKI: If I may, Your Honor.

03:34 5 THE COURT: Sure.

03:34 6 MS. OLSHEFSKI: So if we're moving into the attack on the  
03:34 7 Affidavit of Probable Cause and, specifically, the Franks  
03:34 8 portion, Attorney Casey suggested putting on witnesses first,  
03:34 9 before the Government's witness establishes probable cause. The  
03:34 10 Government objects to any of these witnesses taking the stand  
03:34 11 to testify what they purport to testify to for our purposes  
03:34 12 here today, Your Honor, and this is why.

03:34 13 This is a Franks hearing. So pursuant to Franks v.  
03:34 14 Delaware, the purpose of a Franks hearing is to present  
03:34 15 evidence that false statements were intentionally and  
03:34 16 recklessly included in the Affidavit of Probable Cause or  
03:34 17 reckless disregard for those false statements or omissions were  
03:35 18 recklessly and intentionally omitted from the affidavit that  
03:35 19 were known to the affiant, at the time.

03:35 20 What the Defense purports to put up are witnesses  
03:35 21 consistent with the oaths that have been provided under seal to  
03:35 22 the Court and consistent with certain interview statements that  
03:35 23 were presented to the Government yesterday afternoon. Those  
03:35 24 witness statements refer to witnesses that were never  
03:35 25 interviewed, prior to the affidavit being written and

03:35 1 authorized and the search being executed in this case. So  
03:35 2 that's not the purpose of a Franks hearing, Your Honor.

03:35 3 The argument from the Defense is these are exculpatory,  
03:35 4 and it was incumbent upon DEA to go out and interview all of  
03:36 5 these witnesses to find out, to search for Brady information,  
03:36 6 before writing and submitting the affidavit in this case. And  
03:36 7 that's just not the law.

03:36 8 So 21 witnesses were interviewed, prior to the  
03:36 9 authorization and execution of this search warrant. If the  
03:36 10 Defense wants to bring in any one of those 21 witnesses and  
03:36 11 purport to show that Agent Derr intentionally and recklessly  
03:36 12 omitted information that would make a difference in the  
03:36 13 affidavit, then, he has the right to do that.

03:36 14 But what he's purporting to do is do bring in witnesses,  
03:36 15 never interviewed, who are going to say Dr. Evers prescribed in  
03:36 16 the usual course of professional practice, at all times the  
03:36 17 prescribing was appropriate. I think he's wonderful. That is  
03:36 18 what he is purporting to do, and pursuant to the interview  
03:36 19 statements I received yesterday, that's what they're going to  
03:36 20 testify to.

03:37 21 And that's not the law, Your Honor. And what I would say  
03:37 22 is, this is not a Brady, this is not application of Brady, when  
03:37 23 we're talking about a Franks hearing, and I would refer to  
03:37 24 United States v. Colkley, which is a Fourth Circuit case, which  
03:37 25 is kind of a hallmark case that many cases go back to and refer

03:37 1 to, when this is an issue referring to omissions. I will also  
03:37 2 say that these cases that I'm going to cite refer to cases  
03:37 3 where a Franks hearing wasn't even granted, because this is not  
03:37 4 the law. So, in Colkley, the Fourth Circuit concluded that;

03:37 5 "The Defendant failed to show the officer intentionally  
03:37 6 misled the magistrate, when he applied for a warrant and  
03:37 7 omitted information from his affidavit."

03:37 8 In that case, the officer did not include information that  
03:37 9 six eyewitnesses were unable to identify the Defendant in a  
03:37 10 photo line up. That was omitted. The officer relied on a height  
03:38 11 description from one witness but did not include contradictory  
03:38 12 information obtained from another witness, stating the  
03:38 13 assailant was shorter than the Defendant.

03:38 14 The Fourth Circuit rejected the Plaintiff's argument that  
03:38 15 the Fourth Amendment requires the affiant to include all  
03:38 16 potentially exculpatory evidence.

03:38 17 And in this case, it was evidence known to the affiant.  
03:38 18 What they purport to do is to claim these omissions were  
03:38 19 intentionally and recklessly made by Agent Derr. He didn't  
03:38 20 interview them.

03:38 21 The Court went on to say;

03:38 22 "The rule would place an extraordinary burden on law  
03:38 23 enforcement officers who might have to follow up and include in  
03:38 24 a warrant affidavit every hunch and detail of an investigation  
03:38 25 in the futile attempt to prove the negative proposition that no

03:38 1 potential exculpatory evidence had been excluded. It would  
03:38 2 perforce result in perniciously prolix affidavits that would  
03:38 3 distract police officers from more important duties and render  
03:39 4 the magistrate's determination of probable cause unnecessarily  
03:39 5 burdensome.

03:39 6 "In addition, a broad duty of inclusion would turn every  
03:39 7 arrest or search into a warrant contest. Such consequences  
03:39 8 would, in turn, discourage reliance on the warrants, a result  
03:39 9 the Supreme Court has stated should be avoided in shaping the  
03:39 10 Fourth Amendment Doctrine."

03:39 11 That is United States v. Colkley, Your Honor, and that  
03:39 12 cite is 899 F2d. 297, it's a 1990 Fourth Circuit case.

03:39 13 Another case that relied on Colkley, Your Honor, is  
03:39 14 Mauricia Harrington Wall v. The City of Monroe, this is a 2020  
03:39 15 case out of the Western District of North Carolina. It's cited  
03:39 16 at 2020 WL 6153086. And the Court in this case relied on  
03:40 17 Colkley and other Supreme Court precedent in saying that;

03:40 18 "Although, an officer may not disregard readily available  
03:40 19 exculpatory evidence of which he is aware, the failure to  
03:40 20 pursue a potentially exculpatory lead is not sufficient to  
03:40 21 negate probable cause. Reasonable law enforcement officers are  
03:40 22 not required to exhaust every potentially exculpatory lead or  
03:40 23 resolve every doubt of a suspect's guilt before probable cause  
03:40 24 is established. Probable cause does not require an officer to  
03:40 25 be certain that subsequent prosecution of the arrest will be

03:40 1 successful."

03:40 2 This Court also said;

03:40 3 "Recognizing the decision not to pursue given  
03:40 4 investigative leads is but one of the circumstances we will  
03:40 5 consider in determining the reasonableness of an officer's  
03:40 6 decision to obtain an arrest warrant. The weight of such  
03:40 7 circumstances will, of course, vary widely depending upon the  
03:41 8 nature of the leads."

03:41 9 Again, this is referring to information that the Plaintiff  
03:41 10 in this case argued that law enforcement had a duty to go out  
03:41 11 and search. Just like in this case what the Defense is saying,  
03:41 12 Had the magistrate judge known about all these other witnesses  
03:41 13 that weren't interviewed that say, I think the prescribing of  
03:41 14 Dr. Evers was appropriate, the decision would have been  
03:41 15 different. And they have to say that it was intentionally and  
03:41 16 recklessly, and the law is, known to law enforcement officers.

03:41 17 So to equate this to Brady, that he should have gone out  
03:41 18 and searched for -- this isn't even Brady information, because  
03:41 19 they're not qualified witnesses to say that, I think Dr. Evers  
03:41 20 was wonderful and that he prescribed appropriately for me. In  
03:41 21 fact, pre-trial, the Defense filed motions to preclude  
03:41 22 Dr. Thomas from being able to say that, a Board certified  
03:41 23 anesthesiologist.

03:41 24 Pre-trial, the Defendant filed motions to preclude  
03:41 25 pharmacists from making that determination. And pre-trial, if

03:42 1 there's another witness out there, anywhere, that the  
03:42 2 Government purports to put on the stand, they're not qualified.

03:42 3 So, now, to put this on now -- and I think he's thinking  
03:42 4 that the law is different because he's a doctor and because  
03:42 5 he's not a drug dealer on the street, and that's simply not the  
03:42 6 case, Your Honor. And I can go on and cite more cases, and I  
03:42 7 will cite them for the record.

03:42 8 United States v. Locklear, which is 2012 Westlaw 5845459  
03:42 9 out of the Eastern District of North Carolina in 2012. The  
03:42 10 District Court -- four eye witnesses were interviewed and said  
03:42 11 the Defendant possessed a firearm. The Defendant claimed that,  
03:42 12 had the detective interviewed four additional witnesses, the  
03:42 13 opinion would have been different, and they would have said  
03:42 14 that the Defendant didn't possess a firearm.

03:42 15 The District Court, in rejecting to grant -- refused to  
03:42 16 even grant a Franks hearing and said;

03:42 17 "Interviewing every potential witness to a crime is not  
03:42 18 required in a PC, Probable Cause Affidavit. Courts do not  
03:43 19 require an officer applying for a search warrant to interview  
03:43 20 every potential witness to a crime."

03:43 21 I have more, United States v. Slizewski, which is 809 F3d.  
03:43 22 382, the Seventh Circuit in 2016. Again, the Defendant said the  
03:43 23 District Court aired by not giving me a Franks hearing because  
03:43 24 the officer omitted exculpatory evidence. And the Seventh  
03:43 25 Circuit, again, reiterated that that's not the law. The Court

03:43 1 held that the officers are not expected to be attuned with  
03:43 2 every potential, every potential exculpatory piece of evidence  
03:43 3 out there against the Defendant. As long as there's probable  
03:43 4 cause in the affidavit, the Defense can't show recklessly made  
03:43 5 or false statements, then, that's what the Court needs to focus  
03:43 6 on.

03:43 7 So I would argue that if he wants to bring in witnesses,  
03:43 8 Judge, that were interviewed, and that the information is  
03:43 9 relevant, if they're going to say Agent Derr lied, that's one  
03:44 10 thing, but to bring in all of these people that say, I think  
03:44 11 Dr. Evers was wonderful, not qualified, not relevant, and it's  
03:44 12 not the law.

03:44 13 MR. CASEY: So, Judge, we have briefed the issue of Franks,  
03:44 14 the Government has just issued a recitation of citations, none  
03:44 15 of which relate to what's before the Court, which is an  
03:44 16 evidentiary issue. The Court is the finder of fact and the  
03:44 17 finder of law here. The Court will evaluate and make its own  
03:44 18 decision as to what's admissible and what's relevant to its  
03:44 19 decision, number one.

03:44 20 Number two, the Defense has asserted and will prove today  
03:44 21 that the Government affirmatively lied in the Affidavit of  
03:44 22 Probable Cause, which was tendered to the United States  
03:44 23 Magistrate Judge to obtain a search warrant. We would show that  
03:44 24 the Government was in reckless disregard for the truth. We will  
03:44 25 do that by calling witnesses who will review those facets of

03:45 1 the Affidavit of Probable Cause that relate to their name and  
03:45 2 their information, and they will testify as to why that is not  
03:45 3 truthful information.

03:45 4 And if the Court thinks that the Defense is astray of  
03:45 5 what's relevant, I'm sure the Defense will be promptly notified  
03:45 6 as to the relevance of the utility to the Court of the evidence  
03:45 7 that we wish to adduce today. We have not summoned dozens of  
03:45 8 witnesses, we have tried to address the categories of  
03:45 9 misrepresentations by the Government, so they are somewhat  
03:45 10 representative.

03:45 11 These are people who have traveled over an hour, many of  
03:45 12 them are elderly or disabled, some are from young families. We  
03:45 13 would like to get on with the testimony and invite the  
03:45 14 Government to interpose their objection to the testimony as  
03:45 15 they see fit.

03:46 16 THE COURT: All right, let's speak for a moment about the  
03:46 17 purpose of this Franks hearing. We all understand the focus on  
03:46 18 Mr. Derr who is the Affiant in this case. We agree; right?

03:46 19 MS. OLSHEFSKI: Yes, Your Honor.

03:46 20 MR. CASEY: Correct, Your Honor.

03:46 21 THE COURT: And the contention by the Defendant is that Mr.  
03:46 22 Derr, in preparing the affidavit that led to issuance of the  
03:46 23 search warrant for the Bennett Avenue property included  
03:46 24 knowingly false and materially false statements that, were they  
03:46 25 excised from the Affidavit of Probable Cause, would be liable.

03:46 1 Isn't that what we're looking at here?

03:46 2 MS. OLSHEFSKI: Yes, Your Honor.

03:46 3 MR. CASEY: That is correct, Your Honor.

03:46 4 THE COURT: Now, from my perspective, I need to hear Mr.  
03:47 5 Derr. I'm not comfortable, and I don't think it's prudent for  
03:47 6 me to hear persons who may have relevant testimony, may not, I  
03:47 7 don't know, but before I can even determine that, I need to  
03:47 8 hear Mr. Derr's testimony and I need to hear your cross  
03:47 9 examination of him, so that I can, at least, identify what  
03:47 10 portions of his testimony you maintain were materially  
03:47 11 knowingly false and make my own determination as to his  
03:47 12 credibility as he testifies.

03:47 13 Only then, if I determine you should be allowed to present  
03:47 14 additional witnesses, am I in a position to see whether that's  
03:47 15 necessary. If I don't do it this way and I do it backwards,  
03:48 16 it's not going to allow me to apply Franks and all of its  
03:48 17 progeny properly.

03:48 18 So I expect that you're going to call Mr. Derr now, are  
03:48 19 you not?

03:48 20 MS. OLSHEFSKI: Your Honor, there's a standing issue, so we  
03:48 21 do have one brief witness on standing.

03:48 22 MR. CASEY: Judge, we have standing witnesses, as well. So  
03:48 23 I think that, given the Court's expression, I think we respect  
03:48 24 that and I think we should get on with Mr. Derr and get to the  
03:48 25 less significant issues or less significant witnesses to

03:48 1 follow, since it's not a requisite that we get through those.

03:48 2 THE COURT: Well, the standing issue, obviously, as I said  
03:48 3 in our telephone conference, is just part of the overall Fourth  
03:48 4 Amendment analysis I have to conduct. For economy of use of our  
03:49 5 time, if you're telling me that you have extensive testimony on  
03:49 6 standing, well, then, maybe we should put that later. But if  
03:49 7 it's something we can dispose of relatively quickly, I'd rather  
03:49 8 do that.

03:49 9 MS. OLSHEFSKI: Your Honor, we do have a witness here from  
03:49 10 Connecticut that traveled here last night, he is our witness on  
03:49 11 standing. It's the Government's position that the Defendant  
03:49 12 does not have standing to object to these medical records. They  
03:49 13 weren't his, he didn't own them, he couldn't prevent them from  
03:49 14 being turned over.

03:49 15 THE COURT: I understand the Government's position, and I  
03:49 16 understand -- at least, I think I understand -- that the whole  
03:49 17 purpose of the presentation of testimony will be to show that  
03:49 18 your assertions are correct.

03:49 19 But, again, this is just a matter of how we do this most  
03:49 20 efficiently. It's 20 to 3 in the afternoon, I'm willing to stay  
03:49 21 here all night if you want to get it done, but it's just a  
03:49 22 question of how we proceed. How many witnesses do you have on  
03:50 23 standing?

03:50 24 MR. CASEY: Three, Judge.

03:50 25 THE COURT: You have three. How many do you have?

03:50 1 MS. OLSHEFSKI: I have one. I don't think this witness will  
03:50 2 be long, Your Honor, and then I can go right into --

03:50 3 THE COURT: Well, let's take care of the standing issue,  
03:50 4 since we're going to be staying here.

03:50 5 MR. CASEY: Well, Judge, if I may, just because I'm very  
03:50 6 concerned about I have so many people, some in really difficult  
03:50 7 conditions, it was a monumental task to get them here today. If  
03:50 8 we could get her standing witness out of the way and go to Mr.  
03:50 9 Derr, and then I'll call --

03:50 10 THE COURT: Do you have an objection to that approach?

03:50 11 MS. OLSHEFSKI: I'm sorry, what was that?

03:50 12 MR. CASEY: The Court is not going to rule on standing  
03:50 13 today, the Court is going to receive its information on  
03:50 14 standing. Do you want to call your witness on standing, call  
03:50 15 him, we'll be done with him, then, we will move to Mr. Derr,  
03:50 16 and then I'll call my standing witnesses --

03:51 17 MS. OLSHEFSKI: I'm sorry, but he has to be cross-examined  
03:51 18 before you call those witnesses.

03:51 19 THE COURT: Of course.

03:51 20 MR. CASEY: Yes, direct and cross-examine him.

03:51 21 MS. OLSHEFSKI: That was the plan, I think.

03:51 22 THE COURT: I think what Mr. Casey is suggesting is that  
03:51 23 his standing witnesses would not follow your standing witness.

03:51 24 MR. CASEY: Exactly.

03:51 25 THE COURT: And instead, once we complete the examination

03:51 1 of your standing witness, we would proceed to Mr. Derr. So if  
03:51 2 that's an acceptable way to approach it, let's do that.

03:51 3 MS. OLSHEFSKI: Fine, Judge.

03:51 4 THE COURT: Let's take a break. Regulations require that  
03:51 5 the witness box be cleaned, so we'll take five minutes.

03:51 6 (At this time a brief recess was taken.)

04:21 7 (The following took place in the conference room.)

04:21 8 THE COURT: I wanted to talk to you all about the posture  
04:21 9 of this particular motion. Franks requires that there be a  
04:21 10 preliminary finding that would then entitle the Defendant to  
04:21 11 the hearing. And it seems as though we may have skipped over  
04:21 12 that particular requirement, because I haven't written on  
04:21 13 whether or not you're entitled to a Franks hearing nor have I  
04:21 14 made a preliminary finding that you are entitled to one.

04:21 15 So that raises the question of whether today is an  
04:21 16 appropriate day to hold the kind of hearing that I think all of  
04:21 17 you were contemplating. Because, right now, it appears as  
04:22 18 though we're ready to do an actual Franks hearing, with cross  
04:22 19 examination of Mr. Derr, and then other testimony that, at  
04:22 20 least, from the standpoint of what you've told me, would  
04:22 21 attempt to show that his statements in the affidavit are  
04:22 22 materially and knowingly false.

04:22 23 But I've never made the initial determination that a  
04:22 24 Franks hearing is warranted, and, in fact, I don't think, under  
04:22 25 Franks, which I've just had an opportunity to review, that the

04:22 1 Defendant has given me affidavits or other proof that would  
04:22 2 serve as a threshold basis for my determining that a Franks  
04:22 3 hearing is necessary.

04:22 4 So there's a couple ways to approach this, and it's going  
04:22 5 to require that you tell me what you want to do. One is to  
04:23 6 allow me to make a determination of whether or not you have  
04:23 7 made a preliminary -- the requisite preliminary showing that a  
04:23 8 Franks hearing is warranted here. If that were the case, we  
04:23 9 would not be taking testimony today in the manner in which we  
04:23 10 just discussed, other than on the standing issue.

04:23 11 The other -- and I'll turn to you, Michelle -- the other  
04:23 12 is to assume that a preliminary showing has been made and to go  
04:23 13 forward with this hearing and hear testimony as to whether or  
04:23 14 not there is anything materially false and knowingly false in  
04:23 15 the affidavit.

04:23 16 So I regard this as an important point because Franks and  
04:23 17 the case law under it is very specific in indicating you must  
04:24 18 make a preliminary showing before you get a Franks hearing.

04:24 19 MR. CASEY: Judge, may I speak?

04:24 20 THE COURT: Sure.

04:24 21 MR. CASEY: In this case, we are not arguing that the  
04:24 22 Defense -- that the Government has a burden to search Brady  
04:24 23 material and give a balanced view, we are simply saying that  
04:24 24 when presenting, say -- I'll give an actual example -- the  
04:24 25 information of Dennis Braun who is listed in the Affidavit of

04:24 1 Probable Cause. The Government has intentionally misrepresented  
04:24 2 the doctor-patient relationship in that information, and they  
04:24 3 have put into the Affidavit of Probable Cause affirmative false  
04:24 4 information. And we have obtained, pursuant to Franks v.  
04:24 5 Delaware, 48 declarations under oath from each of those  
04:24 6 witnesses. It's not all the people listed in the affidavit, but  
04:24 7 it's over 40.

04:25 8 THE COURT: And those you filed under seal with me?

04:25 9 MR. CASEY: Yes. So the quantum of evidence of the false  
04:25 10 representations made by the Government, I would argue to the  
04:25 11 Court, is an abundance of evidence justifying a Franks hearing.

04:25 12 THE COURT: May I interrupt you?

04:25 13 MR. CASEY: Yes.

04:25 14 THE COURT: And I understand your position, that you have  
04:25 15 given me what you believe is a more than adequate basis to  
04:25 16 determine that a Franks hearing is necessary. I'm simply saying  
04:25 17 to all of you, I haven't made, on the record anywhere, a  
04:25 18 determination as to that.

04:25 19 MR. CASEY: I agree with you, Your Honor.

04:25 20 MS. OLSHEFSKI: So, Your Honor, what Pat is referring to in  
04:25 21 those oaths, for most of those patients that he's referring, we  
04:25 22 see 69 files. There are, probably, maybe, I don't know, six  
04:26 23 specific witnesses, patients that are individually spoken about  
04:26 24 in the affidavit, and then the only information after that  
04:26 25 about the other files of patients is PDMP data, high doses,

04:26 1 extended period of time.

04:26 2 When they submitted these oaths, where they had their  
04:26 3 witnesses sign off, I believe it was a professional practice,  
04:26 4 legitimate medical purposes, the caveat is it mischaracterizes  
04:26 5 my treatment. They're not saying those numbers are wrong,  
04:26 6 they're saying, It mischaracterizes my treatment.

04:26 7 So that is not a false statement, that is not disregard  
04:26 8 for the truth. Those numbers are directly from the PDMP and  
04:26 9 their witnesses are saying, I'm not saying I wasn't taking  
04:26 10 those drugs, but they're mischaracterized. Falsely represents  
04:26 11 Dr. Evers' care of me. And that's not a false statement, that's  
04:27 12 their opinion, but that's not a false statement.

04:27 13 So that was the Government's issue. When we filed our  
04:27 14 responses to all these motions and went to the lengths we went  
04:27 15 to to attach DEA-6's to talk about -- to point the Court in  
04:27 16 specific portions of DEA-6's, I was shocked that the next day  
04:27 17 we had a hearing scheduled, because, quite frankly, I knew you  
04:27 18 hadn't had time to make that decision, because you were in  
04:27 19 trial with Phil Caraballo.

04:27 20 THE COURT: I was.

04:27 21 MS. OLSHEFSKI: So I was a little shocked, to tell you the  
04:27 22 truth, but I think the Court, and the Government's position  
04:27 23 would be to, please, make a decision on whether a Franks  
04:27 24 hearing is necessary at this point, based upon all the  
04:27 25 information that's there. Because there's a lot there.

04:27 1 MR. CASEY: Judge, if I may, I understand that the  
04:27 2 Government has the impression that the Defense is only taking  
04:28 3 issue with the proportionality of information, meaning, that  
04:28 4 the Government's recitation of the prescriptions is a  
04:28 5 misrepresentation of the entire treatment between the doctor  
04:28 6 and the patient, that's not what it's limited to. I'll give you  
04:28 7 an example, proffer, of the first witness that they will hear  
04:28 8 from.

04:28 9 This witness was interviewed by the Drug Enforcement  
04:28 10 Administration, Mr. Derr, himself, and she explained how she  
04:28 11 was treated by the doctor, her course of treatment, his  
04:28 12 examination, vital signs, all of that process, and then, at the  
04:28 13 end of the interview, she said, Dr. Evers is a good doctor, and  
04:28 14 she insisted that they put that down. None of that information  
04:28 15 is in the Affidavit of Probable Cause.

04:28 16 MS. OLSHEFSKI: Doesn't have to be, Pat.

04:28 17 MR. CASEY: Which means that they intentionally misled the  
04:29 18 magistrate judge about the relationship between that lady who  
04:29 19 they interviewed and the characterization that they gave. Now,  
04:29 20 I understand that the Government wants to sit back and say, No  
04:29 21 harm, no foul, we just put in the pharmacy information. But  
04:29 22 that's not what the whole affidavit is about.

04:29 23 The Affidavit of Probable Cause is a reasonable belief  
04:29 24 that a crime is being committed by Martin Evers, and that  
04:29 25 there's a reasonable likelihood that the fruits of that crime

04:29 1 would be found at his address. To find that a physician is  
04:29 2 outside the usual course, they have to say he's prescribing  
04:29 3 outside the usual course. That's the intent of the information  
04:29 4 they put there.

04:29 5 When they have, themselves, interviewed the patient and  
04:29 6 misrepresented the information, that's the epitome of, at a  
04:30 7 minimum, reckless disregard for the truth or actual false  
04:30 8 statements, which I think the Court should hear from. And the  
04:30 9 Court can determine whether -- as we go through the witnesses,  
04:30 10 whether it's something the Court wishes to hear.

04:30 11 THE COURT: If the Government wants me to make the required  
04:30 12 preliminary showing, then, I think that's what I have to do.

04:30 13 MS. OLSHEFSKI: I would ask you to do that, Your Honor.

04:30 14 THE COURT: I don't know that I'm, at all, comfortable  
04:30 15 ruling from the bench on that. I don't think that's the  
04:30 16 appropriate thing to do here. Both sides have raised  
04:30 17 significant points in their own -- in support of their  
04:30 18 respective positions, I don't want to, in the interest of  
04:31 19 simply concluding this matter, make a decision that's less than  
04:31 20 well thought out, and that is simply the basis of some  
04:31 21 consideration, now, leading to a bench ruling. I think that's a  
04:31 22 mistake.

04:31 23 Now, if counsel has a different view and really wants to  
04:31 24 go forward with this, I can do that, but I would suggest, I  
04:31 25 would suggest that we adhere to what I consider to be the

04:31 1 accepted approach, which is that I make a determination based  
04:31 2 on the affidavits that have been given to me as to whether you  
04:31 3 have now shown me you're entitled to a Franks hearing and look  
04:31 4 at the information that both of have you given me, rather than  
04:31 5 ignoring that preliminary obligation and going right into what  
04:32 6 is clearly a Franks hearing.

04:32 7 So that's my -- my intention is to do it by the book, so  
04:32 8 to speak, which means that, to the extent that this particular  
04:32 9 motion can be dealt with in parts, we can certainly hear the  
04:32 10 standing issue today.

04:32 11 MR. CASEY: Your Honor, I'd rather not do that, to be  
04:32 12 honest with you.

04:32 13 THE COURT: That's fine. But no preliminary determination  
04:32 14 was made by me. I think it warrants an opinion rather than a  
04:32 15 bench ruling. It isn't -- I don't take this lightly, obviously,  
04:32 16 and I think that's what has to be done.

04:32 17 When we had our telephone conference, I viewed it as a  
04:33 18 discussion about the suppression hearing nature of your motion,  
04:33 19 but I did not take into account the need for this preliminary  
04:33 20 determination.

04:33 21 MR. CASEY: If I may, Judge, at the risk of going against  
04:33 22 the wave of authority here, I don't know -- I would argue to  
04:33 23 the Court that it need not issue a separate opinion, it could  
04:33 24 hear arguments of counsel, and I could proffer, there are  
04:33 25 several witnesses here, and if the Court were comfortable

04:34 1 making a bench ruling, then, so be it. If the Court were not,  
04:34 2 after hearing that information, comfortable making a bench  
04:34 3 ruling, then, I understand, and we could await the Court's  
04:34 4 ruling.

04:34 5 MS. OLSHEFSKI: The problem with that, Your Honor, from the  
04:34 6 Government's perspective, is, he only gets that opportunity if  
04:34 7 you grant him a Franks hearing, so that evidence should never  
04:34 8 be before the Court, unless there is a Franks hearing.

04:34 9 MR. CASEY: That's not true. I can submit and I have  
04:34 10 submitted 48 declarations under oath, testimony before the  
04:34 11 Court --

04:34 12 MS. OLSHEFSKI: The Court has them.

04:34 13 MR. CASEY: -- substantiating guidance from Franks v.  
04:34 14 Delaware, the procedure to do so. I have witnesses here for  
04:34 15 whom I could make a proffer to the Court, in the presence of  
04:35 16 the witness, so that the Court has a more fulsome understanding  
04:35 17 of the magnitude of the falsifications by the Government in the  
04:35 18 Affidavit of Probable Cause. It's another level of support.

04:35 19 These people traveled in here, some have babysitters, some  
04:35 20 have medical appointments they've missed, some don't have the  
04:35 21 capacity to drive themselves or have spouses. Some are  
04:35 22 disabled.

04:35 23 MS. OLSHEFSKI: But that's not a basis to hear testimony,  
04:35 24 Pat.

04:35 25 MR. CASEY: It's evidence for the Court to consider.

04:35 1 THE COURT: Well, I'm looking at an opinion of my own in  
04:35 2 another matter where we wrote;

04:36 3 "The preliminary showing a Defendant must make is no light  
04:36 4 burden and puts the Defendant to task by requiring some offer  
04:36 5 of proof that materially false statements were recklessly or  
04:36 6 intentionally made."

04:36 7 Citation to United States v. Darby. Then it continues.

04:36 8 "More specifically, a Defendant must allege with  
04:36 9 specificity what was false in the affidavit, must provide  
04:36 10 proof, must allege that the Affiant had a culpable state of  
04:36 11 mind and must allege that the remaining information is  
04:36 12 insufficient to support a finding of probable cause."

04:36 13 It continues on about;

04:36 14 "Conclusory allegations of untruthfulness are insufficient  
04:36 15 to meet this burden. Defendant must provide an offer of proof  
04:36 16 contradicting the Affiant, such as sworn or otherwise reliable  
04:36 17 statements from witnesses", citing to United States v. Yokshan,  
04:36 18 a Third Circuit 431 Federal Appendix 170, a 2011 case. And, in  
04:37 19 fact, Franks itself make the very same statement in almost the  
04:37 20 same language.

04:37 21 So it seems to me that I need to make a preliminary  
04:37 22 determination, based on your affidavits, as to whether or not  
04:37 23 you've established your right to a Franks hearing. I think to  
04:37 24 do it any other way would be error, and I'm sorry for the  
04:37 25 inconvenience that might arise as a consequence of this, due to

04:37 1 the people who are here, but I'm not prepared to deviate from  
04:37 2 what the Franks decision itself indicates, as well as the cases  
04:37 3 that I've cited in other opinions.

04:37 4 So, now, if you want to take testimony on the issue of  
04:37 5 standing, you've got those people here today, I'm happy to hear  
04:37 6 that. That's entirely up to you, if you want to do it at  
04:37 7 another other, and all of this at once, we'll do that, as well.

04:37 8 MR. CASEY: I'd rather do it at another time, Your Honor.

04:37 9 MS. OLSHEFSKI: That's fine.

04:38 10 MR. CASEY: I do have a request of the Court that I be  
04:38 11 permitted to collect some of the information that these  
04:38 12 witnesses would have provided today to the Court and provide  
04:38 13 that as an affidavit, in addition to that which has already  
04:38 14 been submitted.

04:38 15 THE COURT: You can submit affidavits, I think you're  
04:38 16 entitled to do that. In light of the circumstances, if you  
04:38 17 think there's affidavits that you can put together in short  
04:38 18 order, yes, fine.

04:38 19 As far as concluding for today, I don't know whether you  
04:38 20 want to go back in to court to allow me to indicate what we  
04:38 21 have done, would that be your approach?

04:38 22 MR. CASEY: That would be very helpful, Judge.

04:38 23 THE COURT: Okay, let's do that.

04:38 24 MR. CASEY: Thank you, Your Honor.

04:38 25 MS. OLSHEFSKI: Thank you, Your Honor.

04:38 1 (Discussion concluded in conference room.)

04:47 2 THE COURT: Mr. Casey, in support of your request for a  
04:47 3 Franks hearing, would you state for the record the number of  
04:47 4 affidavits that you have submitted in support of that request?

04:47 5 MR. CASEY: Yes, Your Honor. 48 declarations under oath  
04:48 6 from witnesses, over 40 of whom were identified in the search  
04:48 7 warrant to establish probable cause for the search of the  
04:48 8 doctor's office.

04:48 9 THE COURT: Ms. Olshefski, earlier in this hearing, you  
04:48 10 indicated that, in response to that -- and I think it's in your  
04:48 11 memorandum, as well -- you submitted affidavits.

04:48 12 MS. OLSHEFSKI: Your Honor --

04:48 13 THE COURT: Actually, you submitted the DEA-6's, did you  
04:48 14 not?

04:48 15 MS. OLSHEFSKI: The DEA-6's, as well as the affidavit of  
04:48 16 Agent Derr, with a list of the patients that were actually  
04:48 17 interviewed pre-affidavit.

04:48 18 THE COURT: All right. I've taken this time, as counsel  
04:48 19 knows, to consult the decision in Franks, which is the basis  
04:48 20 for the type of hearing that we need to hold here, and what  
04:48 21 Franks requires is a preliminary finding by me, as the Judge  
04:48 22 assigned to this case, based on the affidavits you've given me,  
04:49 23 Mr. Casey, and any rebuttal that you provided, Ms. Olshefski,  
04:49 24 and that preliminary finding has not been made by me.

04:49 25 Under Franks, a preliminary finding of that nature is

04:49 1 required before a Franks hearing may be held. And I'll just  
04:49 2 briefly quote from the Supreme Court's decision in Franks,  
04:49 3 where they say;

04:49 4 "We hold that when the Defendant makes a substantial  
04:49 5 preliminary showing that a false statement knowingly and  
04:49 6 intentionally or with reckless disregard for the truth was  
04:49 7 included by the affiant in the warrant affidavit, and if the  
04:49 8 allegedly false statement is necessary to the finding of  
04:49 9 probable cause, the Fourth Amendment requires that a hearing be  
04:49 10 held at the Defendant's request.

04:49 11 "In the event that, at that hearing, the allegations of  
04:50 12 perjury or reckless disregard is established by the Defendant,  
04:50 13 by a preponderance of the evidence, and with the affidavit's  
04:50 14 false material set to one side, the affidavit's remaining  
04:50 15 content is insufficient to establish probable cause, the search  
04:50 16 warrant must be voided and the fruits of the search excluded,  
04:50 17 to the same extent as if probable cause was lacking on the face  
04:50 18 of the affidavit."

04:50 19 That is the decision in Franks quoted verbatim, and the  
04:50 20 preliminary finding that would entitle your client to a Franks  
04:50 21 hearing is something I must make, and as a matter of the Franks  
04:50 22 decision, we cannot proceed to an evidentiary hearing unless I  
04:50 23 make that preliminary finding first, and I haven't done that.

04:50 24 So for that reason, we cannot proceed today to hold the  
04:50 25 Franks evidentiary hearing that you are seeking. So what I will

04:51 1 do is I will make -- I will review the materials you've  
04:51 2 submitted, you've indicated, I think, that you wish to submit  
04:51 3 something else as well.

04:51 4 MR. CASEY: Yes, if I may, Judge, I don't want to interrupt  
04:51 5 you. So a number of the witnesses that were here today, I would  
04:51 6 get affidavits to supplement the record. I suspect I could get  
04:51 7 that done within 30 days, Your Honor. And I appreciate the  
04:51 8 Court's consideration that a number of these witnesses came  
04:51 9 from over an hour away and have interrupted their families and  
04:51 10 stuff, that's on me, and I'll collect that information and  
04:51 11 submit it to the Court for the Court's evaluation.

04:51 12 I have one other argument, but I'll pause here until then.

04:51 13 THE COURT: Ms. Olshefski, do you have any objection to  
04:51 14 that approach?

04:51 15 MS. OLSHEFSKI: No, Your Honor. Perhaps, the Government  
04:52 16 would have an opportunity to respond?

04:52 17 THE COURT: Sure. But, again, the point here is the law  
04:52 18 requires, before I proceed to have the Franks hearing that the  
04:52 19 Defendant is seeking, I must make a preliminary finding that  
04:52 20 there is a basis to do so, that has not been done by me, and I  
04:52 21 can't omit a step in the process, even though, by not omitting  
04:52 22 it, there's some inconvenience, obviously, to everyone involved  
04:52 23 in the proceeding.

04:52 24 I'm sorry, Mr. Casey, you were about to say something?

04:52 25 MR. CASEY: I know the Court knows this, but there is also

04:52 1 a facet -- although, the Franks dominates the interest and it  
04:52 2 is the decision that has to be made for efficiency of testimony  
04:52 3 -- there is also a probable cause argument, like a traditional  
04:52 4 suppression issue, but if Diversion Investigator Derr is going  
04:53 5 to testify it's more efficient for judicial resources to have  
04:53 6 that done and Franks decided, either it's in or it's out, we  
04:53 7 would know the scope of the examination.

04:53 8 As the Court alluded to earlier, you've got to hear from  
04:53 9 the case agent first, and then the Court can be informed as to  
04:53 10 how to proceed.

04:53 11 THE COURT: I think, should a Franks hearing, ultimately,  
04:53 12 be held, that holding that along with the traditional inquiry  
04:53 13 into probable cause would be the appropriate way to proceed.

04:53 14 MS. OLSHEFSKI: Your Honor, I would agree with that, and I  
04:53 15 would also agree that Your Honor has to make the decision  
04:53 16 whether or not there is probable cause, sufficient probable  
04:53 17 cause, based upon everything that has been submitted in support  
04:53 18 of false statements, as well, in addition to the Franks  
04:53 19 hearing.

04:53 20 THE COURT: That's certainly true. Mr. Casey has asked for  
04:53 21 30 days to submit his affidavits.

04:53 22 MS. OLSHEFSKI: No problem with that, Judge.

04:53 23 THE COURT: Do you need additional time to submit anything?

04:53 24 MS. OLSHEFSKI: I would request, like, 14 days subsequent  
04:54 25 to that.

04:54 1 THE COURT: Fine. Now, the last issue before, I believe, we  
04:54 2 can adjourn for the day is whether you wish to submit --  
04:54 3 returning to the Daubert issue -- whether you intend to submit  
04:54 4 any further briefing on that?

04:54 5 MS. CONABOY: Yes, Your Honor. If we could submit that at  
04:54 6 the same time, within 30 days.

04:54 7 THE COURT: Sure. Ms. Olshefski?

04:54 8 MS. OLSHEFSKI: The Government does not believe that  
04:54 9 further briefing on the Daubert issue is necessary, however, if  
04:54 10 the Defense submits something, the Government would like to  
04:54 11 respond within 14 days.

04:54 12 THE COURT: All right. And both requests are granted.  
04:54 13 Before we close, is there anything else that we need to discuss  
04:54 14 to keep this case on track?

04:54 15 MR. CASEY: Not from the Defense, Judge. Thank you.

04:54 16 MS. OLSHEFSKI: No, Your Honor. Thank you.

04:54 17 THE COURT: All right. Thank you, counsel, for your  
04:54 18 assistance and input in this matter. We will proceed as we have  
04:55 19 outlined here. Thank you.

04:55 20 (At this time the proceedings were adjourned.)

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## C E R T I F I C A T E

I, KRISTIN L. YEAGER, Official Court Reporter for the United States District Court for the Middle District of Pennsylvania, appointed pursuant to the provisions of Title 28, United States Code, Section 753, do hereby certify that the foregoing is a true and correct transcript of the within-mentioned proceedings had in the above-mentioned and numbered cause on the date or dates hereinbefore set forth; and I do further certify that the foregoing transcript has been prepared by me or under my supervision.

S/Kristin L. Yeager  
KRISTIN L. YEAGER, RMR, CRR  
Official Court Reporter

## REPORTED BY:

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